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**Sexologist as a Profession**
**A Qualitative Study in Sweden**

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**Contents**

- Abstract
- Introduction
- Research on Swedish Sexologists
- Objectives and Research Questions
- Theoretical framework
- Method, participants and procedures
- Results
  - Medical and therapeutical sexologists
  - Professional ambivalence and competence
  - Problem areas and working models
  - Multidisciplinary harmony and tensions
- Discussion
  - Sexology as an interdisciplinary landscape
- Limitations
- References
- Appendix
  - Interview Guide

**Abstract**

The overall objective of this study is to explore the evolution of sexology profession in Sweden, and additionally to compare some of these trends with other European sexologists. More specific, the study aims to get in-depth knowledge of Swedish sexologist’s own description of themselves and their profession. Data was collected through qualitative research interviews with 34 professionally active sexologists and members of The Swedish Association for Sexology, [SFS], 26 women and 8 men, aged 34–88 years. Results show that the informants can be divided into medical and therapeutical sexologists, all of whom identify strongly with...
their primary profession prior to becoming sexologists. Physician as sexologist has
given way to healthcare professionals such as social workers and nurses, whereby
sexology has been transformed into a female-dominated field in Sweden as well as
in other European countries. This paradigm shift has has created tensions between
different approaches. Based on varying skills and educational backgrounds, different
groups of sexologists have emerged: pioneers, competence sexologists, entrepreneurs, research sexologists and the non-professionals. Competition is not experienced toward others within the interdisciplinary realm of
sexology, but rather between those who have professional authority and those non-
professionals who strive for legitimacy in the field.

Introduction

There have been an increasing number of women and men who are seeking
help for sexual problems and/or dysfunctions during the last three decades (Fugl-
Meyer & Giami, 2006; Löfgren-Mårtenson & Fugl-Meyer, 2010). The number of
classified sexual dysfunctions has grown over the past three decades, from frigidity
and impotence in the 1970s, to more than 25 new diagnoses for each sex (Lundberg
& Löfgren-Mårtenson, 2010). Questions regarding lesbian, gay, bisexual and
transgender sexuality and different sexual paraphilias are also areas where women
and men are looking for help, as well as problems related to sexual violence and
problems of sexual compulsions and hypersexuality (Fugl-Meyer & Fugl-Meyer,
2002). The need for sexological competence thus appears to be great, while there is
a lack of in-depth knowledge concerning those working professionally with sexuality
and sexual health in Sweden. There is no consensus regarding the right to name
oneself sexologist, nor is there an exact description of what a sexologist does, or who
can or should perform sexological tasks, or a definite meaning of these tasks. In
addition, some have questioned whether it truly is a profession or rather a kind of
"label" (Fugl-Meyer & Giami, 2006; Löfgren-Mårtenson & Fugl-Meyer, 2010).

Professionalization processes can be described according to the development
of education, authorization, ethical rules and organizations (see e.g. Molander &
Terum, 2008). The evolution of sexology profession has then been an ongoing
process since the mid-1960s in Sweden (Dahlöf, 2008; Löfgren-Mårtenson & Fugl-
Meyer, 2010). Professionals have sencethen chosen to join different sexological
networks and associations, to undertake training in sexology, and/or do research
within a broader sphere of sexology. The first Swedish courses in sexology were
offered sporadically in the late 1960s and more regularly from 1974 (Dahlöf, 2008).
Today, courses in sexology at basic and advanced (master) levels according to the
Bologna declaration[1] of 1999 are available at several Swedish universities in the
faculties of medicine, psychology, social work and health and society. Furthermore,
thereare large numbers of applicants to these courses and to the master program in
sexology at Malmö University (Dahlöf, 2008; Löfgren-Mårtenson, 2008; Löfgren-
Mårtenson & Fugl-Meyer, 2010).
The Swedish Association for Sexology,[SFS], was founded in 1980 with the aim to promote networking, to exchange experiences, and promote scientific and clinical collaboration. Membership is offered to professionals or those in non-profit positions working with sexological issues. In May 2011 there were 153 members, of which 102 paid memberships.[2]

Requirements for an authorization for Nordic sexologists were accepted in 2000 through the Nordic Association for Clinical Sexology,[NACS], and the first authorizations were carried out in 2002. The impetus was to endow various clinical sexological activities with a hallmark of quality, and to clarify the sexologist's skills for those seeking help. To date, there are 33 certified clinical sexologists and 20 certified sex counselors with diverse professional backgrounds in Sweden.[3] In 2008 an authorization as sexuality educator, sexual health promoter and sexual science was started as well, and there is 1 researcher and 1 educator authorized so far.

NACS has also developed and adopted ethical guidelines for professional sexologists.[4] The intention is to clarify and establish guidelines for those who work professionally with sex therapy, sex counseling, sex education and sexual research, and to inform and protect those who seek help. The sexological guidelines state that these should be a supplement to the guidelines that apply for the basic professional sexologist. These specific sexological guidelines relate, inter alia, to the sexologist-client relationship and focus the sexologist's responsibility for maintaining high professional standards and for the dependent relationship that can arise in a therapeutic situation.

Research on Swedish Sexologists

What do we know so far about those who call themselves sexologists? In 2001, Fugl-Meyer and Giami (2006) performed a survey geared towards members of SFS, and to all individuals/out-patient clinics listed in the national telephone directory in the "yellow pages" as "sexologist" and "sexological outpatients practices". Of the 222 in the target sample 157 chose to complete the questionnaire, and among these were 143 active in clinical sexology. Their median age was 50 years (24–81 years) and an overwhelming majority were women. Most worked as nurses, midwives, psychotherapists or doctors. Among psychotherapists, the group consisted of marriage and family therapists, psychologists and social workers. Most were employed in the public sector and nearly all had at least a post-graduate education in sexology, while almost two-thirds also had training in psychotherapeutic modalities. More than a quarter had participated in sexological research, published scientific reports and participated in sexological conferences and seminars. A similar picture emerges of sexology students at the basic and advanced levels, showing that the majority are women in midlife (Dahlöf, 2008; Löfgren-Mårtenson, 2008; Löfgren-Mårtenson & Fugl-Meyer, 2010). About half are social workers, half are nurses or midwives; and there is a smaller group of psychologists and a few physicians working with sexological concerns. Thus, in-depth knowledge about Swedish sexologists' own
descriptions of their profession is still missing, and also about their reflections on trends in the on-going professionalization process in Sweden.

**Objectives and Research Questions**

The overall objective with this study is to explore the evolution of sexology profession in Sweden, and additionally to compare some of these trends with other European sexologists. More specific, the study aims to get in-depth knowledge of Swedish sexologist's own descriptions of themselves and their profession. What characterizes the sexological professionalization process in Sweden and how can it be pronounced (e.g. education, authorization, ethical rules and organizations)? How do professional sexologists describe themselves (e.g. age, gender, sexual orientation, professional background)? And, how do the sexologists describe their profession (e.g. professional activity, target groups, type of sexual problems, working models, professional authority and culture)?

**Theoretical framework**

Guiding the analysis was a sociological perspective on the professionalization process. The concept of professionalization is then multifactorial and refers usually to a type of professional organization in which people with some education are given the right and jurisdiction to more or less independently perform certain tasks (Abbott, 1988; Molander & Terum, 2008). In a long-standing Western tradition, physicians, lawyers and priests have counted among the classic professions on the basis that they have clear exam regulations leading to a professional identity, and that the profession is governed by explicit rules. Traditionally, it is by combining professional activity with a long university education and research that a subject or field becomes developed and professionalized (Johnson & Lindgren, 2001; Smeby, 2008).

Characteristic of the development of a profession and its skills are also criteria related to systematic theory, professional authority, ethics, professional culture and society's approval. Molander and Terum (2008) emphasize that a professional thus becomes linked to specific normative expectations, both within and outside the profession.

As society evolves, there is also a change in the perception of professions and the criteria for these. The introduction of the concept of semi-professionals can both be seen as a way to deal with confusion about differences of degree between different professional groups, and as a way to make it clear that any of the characteristics required for inclusion in a full-fledged profession are missing (Hermansson, 2003). In Sweden, nursing, social work and teaching below university level are considered to be within the semi-professional domain, although this may change based on new conditions applicable to further education and research.

The professionalization of an occupation can also mean different things; in the study at hand, it refers to a quest and work for jurisdiction between different
professional groups (Abbott, 1988). This quest takes place in different arenas: the state, the legal system, the public, the media debate and within activities and organizations, i.e. in a variety of workplace settings. To claim a professional field means that a group of professionals would have the right to perform several tasks that they believe belongs to them. Claims can also be about an exclusive occupation being sought or that a professional field is shared by several professional groups who jointly have access to performing certain professional duties. With regard to the interdisciplinary field of sexology, this becomes particularly interesting, since the field consists of different professional groups that are intended to relate well to each other and to the sexological issues they face in their profession.

Jurisdiction work can also be described in terms of boundaries, turf battles and boundary work (Fournier, 2000; Light, 1988). Using a landscape metaphor, professional territories are studied where borders are defended in a competitive and bargaining position in relation to other professions. It is in the creation and maintenance of these boundaries that a specific occupational group is formed. Initially, local boundaries are created, which are then bound together into larger regional and national structures, which in turn form the professions (Abbott, 1995). Boundary work is conducted at various levels, from individual professionals in the workplace to representatives whose task it is to take advantage of professional interest groups. Professionals must accept the consequences of the boundary work of others in the form of others’ claims about who does what. By challenging and renegotiating the boundaries, professions are changed. However, Fransson (2006) argues that there is a tendency to increasingly speak of professionalism rather than a profession; there is a diminishing focus on formal qualifications and more on the actual professional practice and its situational and individual practitioners. Trust and confidence are then key concepts of the practitioner's legitimacy.

Method, participants and procedures

Qualitative interviews have been selected as the research method in order to elucidate the research questions that deal with the sexologists’ own descriptions of their profession. The ambition of qualitative studies is to explain and illuminate the character of a phenomenon and its meaning (Starrin & Renck, 1996), in this case the professionalization process concerning the sexologists in Sweden. The intention was not generalizing, but to gain a deeper understanding of the area of research and to highlight the complexity of the inquiry (Widerberg, 2002). This is relevant when seeking access to the voices of the sexologist experiences and reports, and to gain comprehensive knowledge about this sample of professionals.

Through a brief solicitation notice on the homepage of SFS, informants were able to report their interest and consent to the study according to the provided research ethics guidelines. The association consists to date of 102 paid members (retrieved from SFS: http://www.svensksexologi.se/), of which 34 members announced their participation in the study. The sample consists of 26 women and 8
men aged 34–88 years, working in different parts of Sweden. The aim was to get a variation of professional backgrounds, working fields, and also concerning sizes of towns where they work. Not least, the intention was to get a diversity concerning age and gender, though research show that attitudes and norms can vary according these factors (Månsson et al., 2004). In addition, a variation of sexual orientation was desirable in order to get information of this as another conceivable factor of importance.

An interview guide (see Appendix) was conducted on the basis of the research questions and with topics to be covered: professional background, professional content and specialization, and finally professional network. These themes were used as gate ways for the interviews, where the informants were encouraged to describe factors of importance and their approaches to the sexological profession. Additionally, informants describe their commitment and motivation, and their experience of how employers perceive their competence and authority in the field.

The informants were interviewed individually during 60–90 minutes. Each interview was recorded on tape and subsequently printed verbatim. The informant's own emphasis on certain expressions in the selected citations is presented in capitals, and the enthusiasm and commitment is expressed by exclamation points. Irrelevant phrases and sentences are indicated by [...]. Clarifications needed for understanding the meaning of the phrase are also put within the bracket signs. An empirical analysis model is employed by adherents of the Chicago School (e.g. Abbott, 1997; Gerhardt, 2000) in the attempt to broach the descriptions provided by the sexology professionals concerning their work. More specifically, an initial structuring of the chosen themes were conducted and thereafter analyzed with the support of the selected theoretical frame work (e.g. boundaries, professional authority, and professionalism). The aim was to seek for trends, patterns and common themes in the data, but also to seek for variation and diversity in order to get a complex and sterling picture of the research area. Kvale (2009) points out that validity in qualitative research is about credibility and a careful description of the approach and the purpose of the study. In this study some of the informants have got the opportunity to discuss and review the interpretations, which is one way of confirming the results (e.g. Bryman, 2011). The informants are sometimes presented according to their prior profession, age and gender, in order to get a broader picture of the variety of the sexological actors in the field. Other times, these factors are withdrawn because some informants stressed the importance of not being categorized in a narrow way.
The descriptive results are presented according to the following themes that have arisen during the analyses process: a) medical and therapeutical sexologists, b) professional ambivalence and competence, c) sexual problems and working models, and d) multidisciplinary harmony and tensions. The emerging sexological landscape is then discussed, including if the sexologist can be viewed as a distinct professional according to specific sociological constructs and theories, and the potential limitations of the study.

**Results**

**Medical and therapeutical sexologists**

*Age, gender and sexual orientation.* The majority of the informants were middle-aged women, as confirmed in previous research on sexologists and sexology students (Dahlöf, 2008; Fugl-Meyer & Giami, 2006; Löfgren-Mårtenson, 2008). The importance of factors as age and gender in the treatment of clients were stressed by the informants, while reflecting on how the practitioner's own life experiences affect the therapeutic situation and the therapeutic relationship. However, a few emphasized instead the importance of meeting the client with empathy, regardless age and gender. A 52-year-old female sexologist and psychiatrist says:

> One can overcome both age and gender ... But sometimes it matters. I think if you are very young and meet an elderly person, it can sometimes be difficult to gain credibility.

Most of the informants were heterosexual and partnered, a relationship status that also applies to the majority of the master students of sexology at Malmö University in Sweden (Löfgren-Mårtenson, 2008; Löfgren-Mårtenson & Fugl-Meyer, 2010). Many emphasized the importance of reflecting on these aspects as well in client interactions, and not assuming a heteronormative perspective. But a 47 years old female sexologist and nurse state that there are still a lot of prejudice against lesbian, gay, bisexual and transgender sexuality, even among sexologists. She is legally married to a woman, and says that this is usually met with passive silence among colleagues.

A couple of informants would not categorize neither themselves or others based on age, gender and/or sexual orientation. They argue that it becomes a too narrow description of a person and his/her life. Instead they emphasize the importance of being transgressive, both in their own frames of reference and in the treatment of clients. One person states:

> I: I believe I have no gender. Which gender do you want? The social or biological?
> L: Yes, it is different according to emphasis.
> I: In that case, I'm genderless!

**An interdisciplinary group.** Overall, the informants consist of an interdisciplinary group of professionals. Almost all interviewed informants have a basic profession
within the health and human services sector; about one-third have social work degrees, a third nursing or midwifery diploma, and less than a third have a medical degree specializing in gynecology, psychiatry, neurology, or have a degree in psychology. According to this it is possible to divide the informants into "medical" (e.g. nurses, midwives, medical doctors) and "therapeutic" (e.g. counselors, psychologists, social workers with further education in psychotherapy) sexologists according to their original profession and working models. Thus, other studies show that the educational background of the sexology students in the new millennium is different from previous decades, in that physicians have more or less disappeared from the field (Löfgren-Mårtenson, 2008; Löfgren-Mårtenson & Fugl-Meyer, 2010).

The informants state that they lacked sexology in their basic education and therefore felt a strong need for further training when they began their careers. Many have several courses in basic and clinical sexology, and accentuate the importance of sexological competence. Furthermore, three of the informants have earned a doctoral degree, one has an honorary doctorate, and a few others are currently doing sexological research. Overall, the interviewees emphasize the importance of sexological research and point out the value in taking part of current studies, engaging oneself in research and/or work in environments steeped in critical thinking.

The older informants have been trained in or outside their country by other prominent sexologists before there were Swedish courses in sexology. Thereafter, they have often been involved in starting sexology programs and courses in Sweden. A male sexologist and physician, 79 years old, told about his search for literature on the subject at his old university library in the early 1960s:

*If you went to a library to borrow some books, they looked sternly at you and said: "No, you do not get to borrow these books, they belong in the head librarian's toxic cabinet!!"

Although the informants stress the importance of sexological education to gain insight into various sexological scientific perspectives, some argue that these courses are to be regarded as a superficial "smorgasbord", where skills are rarely deepened. A 54-year old female psychologist who first studied sexology in Sweden says:

*I did not really get what I wanted. And then I went to Copenhagen[Denmark] and studied psychotherapy which was ... focused on addressing sexuality or working with sexuality and it was my first step[to a psychotherapeutic education].

In addition to performing clinical work, some of those interviewed also work as teachers, like some of the professionals in the Fugl-Meyer and Giami study (2006). They lecture in their "special areas of interest," e.g. sexual paraphilias, gender reassignment, sex therapy, sexuality and disability, etc., during conferences and training days and/or as course instructors at the university level. The importance of participation in this wider dissemination of knowledge is emphasized by these informants. A female social worker and sexologist, 51 years, enthusiastically states that she is training staff in the treatment of sexuality for people with disabilities, which is much appreciated.
**Working fields.** The informants work in healthcare (youth clinics, oncology clinics, women’s and urology clinics, sexual medicine clinics), in county facilities (schools, refugee centers, family therapy offices), churches (pastoral counseling), rehabilitation and board-and-care facilities, as well as within associations and various organizations (counseling and sex educational facilities). This is inline with Fugl-Meyer and Giami’s (2006) compilation study of Swedish sexologists, where 95% were found to work in the public sector. But because there are so few full-time public sector positions available, several sexologists work in private practice. Fugl-Meyer and Giamis (2006) reported that 11% work privately full-time, and 20% by combining an additional job with private practice. None of those interviewed were contracted with the county public healthcare, which means that to the potential client, the cost of obtaining sexological help is high. A female sexologist speaks indignantly about the difficulty in obtaining a contractual agreement: I do not carry a contract and CAN’T OBTAIN any healthcare contracts; the reason is, they say, is that "there is no need for treatment!" That's what the council at the county responds to my direct questioning. It's been entered into the official minutes from meetings! "There is no need for treatment by either private practice sexologists or psychiatrists!"

**Professional ambivalence and competence**

Regardless their education in sexology the interviewees appear in doubt before calling themselves sexologists - what are actually the criteria? And is there even such a title (c.f. Fugl-Meyer & Giami, 2006)? Sex counselor, sex and relationship consultant, or sex and relationship therapist are examples of job titles that some interviewees use instead, sometimes voluntarily and sometimes at their employer's request. This ambiguity makes it difficult for the public to know who to turn to when seeking help, according to several informants. A male social worker and sexologist, 38, said:

*My business card says social worker, B.A., certified sex counselor from NACS. But ... ordinary people ... maybe it's a little difficult for them to understand all the titles; I usually say that I am a social worker and sexologist. And then it's more like an explanation ... to make people understand the kind of education I have.*

**Authorization.** It is only a small number of the informants that have sought for an authorization as sex counselors or clinical sexologists, and none as a sex researcher. One reason is that the application process is perceived as too cumbersome, and some mention difficulties in meeting the required criteria for experience in sexological counseling and therapy training, and that the filing fee is too high. In addition, several of the informants, such as nurses and physicians, already have licenses covering the practice of their primary professions and therefore experiences limited use of an additional authorization as a sexologist. Nevertheless, the majority emphasize the importance of an authorization because it serves as a stamp of approval, to the benefit of sexologists themselves and for the clients and the communities they encounter in their work. A female sexologist and psychiatrist talks about why and when she uses the title authorized clinical sexologist:
I think that it puts greater [professional] authority behind it. So, I use it when I make statements or write anything related to sexology, but not when my work concerns psychiatry. I imagine that it is relevant in terms of showing that I am ... stating something I am competent to speak about!

Several think that it is too much "amateurishness" in the field, and too easy for people to call themselves sexologists. Then, authorization is seen as an important way of being able to distinguish between those who are regarded as competent, and those who are not. A female sexologist and social worker says with emphasis and revolt:

Of course, I know that the authorization is a very important part. Anyone can call himself or herself a sexologist! […]. So the authorization still shows that you have a certain amount of training, you have supervision, you have had personal therapy and whatever else you want. It offers some guarantee that we are working ethically, compared to many others!

Most of the older informants have been grandfathered into the association as authorized clinical sexologists. This means a dispensation from the current guidelines and rules; many years of working experience with sexological issues, and/or having created sexological courses and training before there were any available. Sometimes this is also a way of showing gratitude to those who have worked with sexology their whole professional lives.

**Problem areas and working models**

*Different types of sexual problems and dysfunctions.* The sexual problems that the informants are facing can be divided into physiological, psychological, relational issues, or related to life crises and traumas. Problems are generally associated with the client's age, gender, and other living conditions. Several of the informants point out that sexual problems often are contextual. A female sexologist, 55 years old, tells about the types of questions clients have at her private clinic:

I meet everyone, from the 14-year old who is concerned that his penis is too small, to 70-year olds … the lady who has met the new love … the first in 60 years, and who wants to keep an eye out for not making the same mistake as last time.

The physiological problems deal with diseases and/or functional impairments that affect sexuality. Sexologists working in oncology clinics talk about patients who receive chemotherapy and/or who have undergone cancer surgery, which involve changes in both physical and psychological sexuality. A female sexologist and a nurse, 46, says she mostly encounters women who are seeking help for low sexual desire. The reason may be that they receive anti-estrogen treatment, with the consequence of feeling desexualized and without a feminine sexual identity.

Psychological problems are often about sexual identity at a deeper level. A few of those interviewed work with gender reassignment issues and evaluation of clients who have gender dysphoria. Others see clients who suffer from severe sexual
dysfunctions and who engage in sexual deviance. A psychiatrist describes his work at a center for sexology and state that he mostly work with clients who are diagnosed with so-called hypersexuality, but also with regular sexual dysfunctions as well. Another area for sexologists is past traumas such as sexual assault or abuse, experienced by clients either as perpetrators or victims at county practices for refugees.

**Changes over time.** Several of the informants, who have worked for many years, describe changes that have occurred over time, in types of sexual dysfunctions or problems that motivate clients to seek help. Twenty years ago, it was common for clients to seek out information about basic sexual functions, such as how to reach orgasm. This type of information is now readily available, primarily through the Internet but also in other media. Erectile dysfunction was also a common therapeutic problem before medical treatments were introduced in the late 1990’s. A female sexology and social worker, 61 years old, says:

*So these men ... they really don’t exist to that extent anymore – the older men with impotence problems or concerns. And we think that one reason it might be that medication is now available, Viagra, for example.*

Another change observed by the interviewees is that more people are now seeking help due to the sexual side effects of medications. This may include the pharmacological treatment of depression that can alter sexual desire; in addition, many are concerned about contraceptives that affect desire and/or sexual function. Overall, it is more common nowadays for both men and women to seek help for desire disorders. Younger women are also coming in to address pain during intercourse. The interviewees believe that this phenomenon is about social factors, the media, appearance ideals and demands on sexual performance. Another female sexologist who has worked for over 20 years at a sexological practice says:

*And what we’ve seen is that there is a huge group that has only increased, and they are young women with pain. Inability to have sexual intercourse, pain during intercourse. This is a group that has become ALL THE MORE larger!*

The informants also describe new kinds of sexual problems. A psychiatrist mentions patients who need counseling because of "too much sex on the brain," and says that it is hard to know if this is a new problem or if there is a social phenomenon triggering the issue. She also tells of patients who have been convicted of child pornography offenses and who believe that their sexual attraction to children occurred when they obtained an Internet connection. Another example associated with the Internet breakthrough concerns people seeking help to stop porn surfing on the Web.

There are also new trends in transgender therapy, as clients can now visit reassignment clinics to alter some aspects of gender while retaining others; this is in comparison to earlier days when complete sex/gender reassignment was required. A female psychiatrist offers examples of people who cannot be classified in the traditional way of examining gender dysphoria:

*There may be people who perceive themselves to be two genders, or who want to assume some aspects of gender reassignment, but not the*
whole thing ... Normative bi-genderedness is one of those concepts that didn't exist too long ago.

Several of the sexologists also talk about changes in attitudes related to sexual violence, which seems to have become an almost "accepted" part of society. The view of rape and the offender has changed, they say. A female sexologist and gynecologist, 65 years old, retrospects and state that rape somehow has become a part of life, not accepted but as an existing every day phenomena.

Finally, many sexologists point out that the more sexological resources become available, the more opportunities there are for clients to seek help. It may seem like sexual problems have increased, but perhaps it is about the availability of more sexologists in the community. In addition, other professionals and colleagues are now aware that there is sexological help, so they can refer clients to the proper professionals. One sexologist state that in general, there is less taboo and shame around seeking help for sexological problems today, and it also increases the number of those wanting services. Nevertheless, the informants experience that the number of sexologists addressing these problems is too small, which is also noted in the Fugl-Meyers and Giami (2006) study.

**Operational working models.** Most of those interviewed work alone and a few in pairs or in teams where both medical and therapeutic sexologists were included. The medical sexologist group report that they collaborate across clinical boundaries when possible. The opportunities for interdisciplinary work is appreciated by informants who believe that it is often necessary, in order to help the individual or the couple. But it can also mean a lack of clarity vis-á-vis clients, as it is sometimes difficult to know what kind of treatment clients expect from a sexologist. In general the interviews show that the medical sexologist treats sexual problems based on physiological perspectives, which means that the sexual physiology is in focus but in a social and psychological context. A sexologist and physician describe this as follows:

> I work from a sexuo-physiological model, one can say. I also see emotional life as some kind of physiological input. It gets transformed into physiology when the soul takes it in, and stress gets created, for example. It's a very important factor, stress reactions of various kinds. They bring on disturbances in sexual functions.

Others say they work mainly from an informative and educational standpoint, and rarely meet clients more than for a few sessions. If a client has a cancer diagnosis, sexological issues are overshadowed by disease progression or recurrence. A female sexologist and nurse says that her patients usually need concrete advice and only come once or at maximum 6–7 times. Several of the therapeutic sexologists instead describe an eclectic approach to working models and theories, which are linked to the primary profession or to additional training in psychotherapy. A female sexologist and social worker explains how she and her colleague work together:
We have worked very systemically. Sometimes, it is one of us that drives the conversation and the other reflects. And then we all reflect openly in the room. [...] We both have Gestalt training and we use some constructs from it. And our psychotherapy education is psychodynamic. It’s so much Freud.

Those who work with couples say that they proceed from communications theories, since a previously significant sexual problem may disappear once a couple begins to talk about sexuality. Others describe their work at different levels based on the so-called PLISSIT model (Annon, 1976), where the first level indicates permission to talk about sexuality (Permission); the second about sex and relationships (Limited Information); the third offers specific instructions (Specific Suggestions); and the fourth provides sex therapy (Intensive Therapy). Others use sensuality exercises (Wagner & Kaplan, 1993), as a model for treating low or absent sexual desire. The aim is then to reduce the client's or couple's worry or performance anxiety often associated with sexuality when there has been some type of resistance or dysfunction for some time.

**Multidisciplinary harmony and tensions**

The interviewees stress the importance of viewing sexuality from a holistic perspective and from different scientific fields. As mentioned earlier, they state an ideal way of working interdisciplinary, either in a team with different professions, or together with a colleague with a different primarily profession. However, several of the informants in the same time described difficulties with the multidisciplinary field of sexology; it can create tensions and competition between different perspectives. It is also complicated to agree on particular systematic theories and models that all sexologists should proceed from. A male social worker and sexologist reflects:

*I think it is difficult to agree. I think it is simply the problem with working in the interdisciplinary mode. That we should see it as an asset and not a hindrance. I think it’s a pity that there are “forces” [...] that there are trends that you should keep it in medicine or psychology. I believe that sexology belongs in the hands of many sciences. And social work and sociology are but two sciences among many! There could be many more, there could be economics, law, etc. The most important thing is to broaden your vision and to see that sexology is everywhere!*

Another cause of tension is that sexologists sometimes must perform the same duties, despite a difference in basic education, and in addition with different salaries. Some consider this to be difficult or questionable. Others believe that this way of working is positive because it strengthens the role of the sexologist and thus the entire subject area.

**Organizations and network.** All informants are members of SFS, and some are also members of the International Academy of Sex Research, [IASR], which is mainly targeted toward sex researchers. Many enthusiastically describe the significance of these associations: easier access to current research from different scientific perspectives and opportunities to make connections and find collaborators,
both national and international. Some informants tell that they have been instrumental in starting up networks and associations in sexology in the 1960s and are known charter members.

But some criticisms appear toward the Swedish association among the informants: there have been times where the same people have been sitting too long on the boards, and there has historically been a medical dominance. The consequences are that it has been difficult for young or new members to reach senior positions, and there have been too many men in leadership positions, given that the majority of the members are women.[5] A female social worker and sexologist becomes dejected when she thinks back over the 20 years she has been a member:

*The association was with these guys at the top.[...]. Supposedly sexology is an interdisciplinary profession, and then it becomes important that it’s not, just medical experts who are sitting in power!*

**Ethical guidelines.** There are not a consensus of the use and meaning of specific sexological guidelines among the informants. Some state that they already have ethical guidelines to proceed from in their original healthcare education. Others highlight particularly sensitive situations that may face sexologists, and they believe on the other hand that there is a strong need for specific sexological ethical standards. As an example, this may include the view of erotic minorities and marginalized groups concerning sexual paraphilias, sexual abuse and prostitution.

**Supervision and mentors.** Several of the informants point out that it is necessary to have supervision when working with sexology; this is confirmed by the sexologists in Fugl-Meyer and Giami’s (2006) study, where 90% had supervision. But only a few of the interviewed sexologists have in fact supervisors with sexological competence, since there are only a few such supervisors available in Sweden. A female sexologist and social worker describe instead informal supervision in groups with other colleagues in medicine and psychiatry. Others talk about older or more experienced colleagues who acts as mentors. A male sexologist tells about his colleague who read every single journal that he wrote over 25 years and was willing to give feedback based on his medical perspective. A female sexologist enthusiastically describes contact with “Y”, her mentor, and says:

*And Y’s importance cannot be emphasized enough! We’ve been calling him all these years if it is something we wondered about or if we needed special supervision.*

Overall, it becomes clear in the interviews that the sexologists are part of a relatively limited group, both nationally and internationally, where many have known each other for years. Through their sexological networks, informants meet regularly and can thus maintain and deepen their contacts over time. These personal and professional ties help to strengthen the interdisciplinary cooperation, but also contribute to tensions created and maintained by some fundamental differences in the primary professions, and sometimes between individuals. However, the main tension described is not between different groups of well-educated sexologists, but
against those who are claiming the sexological competence without being regarded as qualified by the informants.

Discussion

Sexology as an interdisciplinary landscape

From medical and male dominance to the social and the female. The image that has emerged of the sexological landscape in this study can be described as many large and small islands with bridges between them (see also Fournier, 2000; Light, 1988). Inside this metaphor, the bridges are interconnected between various disciplines and professions within the multidisciplinary field of sexology. The study also shows the shifts from a medical dominance to a more psychosocial therapeutic emphasis. Other research suggests that physicians and medical sexologists have almost totally disappeared among younger sexology students (Dahlöf, 2008; Löfgren-Mårtenson, 2008; Löfgren-Mårtenson & Fugl-Meyer, 2010), but the medical group is still relatively large among the older professionals in this study. In hierarchical terms, this can be expressed as the classical medical profession has given way to semi-professionals such as for example social workers and nurses.

It is also clear that gender-related changes and shifts have taken place and that sexology increasingly has transformed into female-dominated field, as confirmed by the Fugl-Meyer & Giami study (2006). In the large groups of social workers and nurses, i.e. the therapeutic sexologist group, the majority are women. Internationally, this trend is also present in other European countries as for example the United Kingdom (Wylie, de Colomby & Giami, 2004), Finland (Kontula & Valkama, 2006) and Denmark, Norway and Italy (Giami & de Colomby, 2006). Nowadays it is also true in France as well (Giami, Chevret-Méasson & Bonierbale, 2009), even though it used to be male dominated (Giami & de Colomby, 2003). It is essential to note these changes, particularly since sexual norms, behavior patterns and codes are culturally linked to gender and generational cohorts (Månsson et al., 2004).

Paradigm shifts also change the use of different working models and sexological theories and create tensions between different approaches. Criticism has been directed by some toward the so-called "medicalization" of sexology, while others cite the importance of meeting sexological problems with pharmacology where it is needed. Still others see sexology from a psychosocial and/or cognitive-behavioral perspective and recommend counseling, or a combination of therapy and pharmacological treatment. In comparison to France where physicians used to be dominating until recently, the medicalization of sexual problems still is more common there than in Sweden (Fugl-Meyer & Giami, 2006; Giami & de Colomby, 2003).

Various groups of sexological actors. Among those interviewed are a smaller group of sexologists that can be called the Pioneers. They began their sexological career in the 1960s-1970s, and physicians and doctors among them dominate this group. Several co-founded the Swedish Association for Sexology, created courses in sexology and formed clinical centers. These people were and still are, to varying degrees, the central figures in sexological contexts: at conferences, in leading functions in the sexological associations, and even in some cases in the
media. Pioneers rarely have formal training in sexology, as this previously did not exist. Their sexological competence is based on their clinical experience and their work with training and supervision in sexology. Pioneers have worked extensively with sexological issues for a long time and are often authorized as clinical sexologists through the grandfathering principle. Several of the informants describe their work as a "life calling" and state a strong personal commitment, which can also be expressed as Pioneers holding a strong professional identity and also significant authority as sexologists (cf. Johnson & Lindgren, 1999).

A large group of the respondents stress the importance of solid competence with a basis in clinical practice and extensive training, both in their primary profession and in terms of further education. Several of these sexologists also stress the importance of further training in therapy, and ongoing supervision to do so. Many of the informants have obtained authorizations as clinical sexologist and sex counselor. Thus this group - the Competence sexologists - are distinguished against those who call themselves sexologists but lack this significant body of education and training. Much like the Pioneers, this is a group with a sense of a strong professional authority, often rooted in their primary profession.

Several of the interviewed sexologists are engaged in private practice full or part time. In some cases it is because they have felt opposed by their employer in the workplace and therefore "gave up" and opened their own office. In other cases, there has been an incentive to build a private practice with a sexological focus, which otherwise might not be possible within a public organization. In a few cases, it has been about obtaining a financially lucrative position in combination with a perceived demand for sexological services. It can also be about driving forces such as a desire for the professional freedom and flexibility that exist within this group, which we might call the Entrepreneurs. Whatever the reason, we can conclude that a new so called commercialized professionalism is emerging, which is not only focused on professional competence but also on entrepreneurial skills. Dellgran and Höjer (2005) have labeled these measures as a strategy of professionalization. Other strategies are as previously mentioned the authorization, sexological training, membership in sexological associations, mentoring, networking and research. There are varying levels of professional authority among the Entrepreneurs, mainly depending on the primary profession of the sexologist.

Although informants generally are very well educated, they are only a few with doctoral degrees. Nevertheless, it can be said that conducting research is valued among the informants, and that the group of Researchers has a high reputation and status among the remainder of the various sexological groupings. Research related to clinical practice and treatment is valued highest by those who are affiliated with the practice of clinical sexology.

Finally, the interviewees describe a group that is not listed among the informants. We can call this group "charlatans" or the Non-professionals as they, unlike the others described, are lacking in human services training and extensive courses in sexology. Sometimes, this group has a prominent role in the media and
represent sexologists as online advisors, in magazines or on television, but their formal competence is perceived as ambiguous by the informants. This upsets the interviewees who, regardless of personal affiliation with the above groups, believe that the Non-professionals should not be working as sexologists.

**Interdisciplinary professionalism - borders that open and close.** Within all these groups are sexologists with different primary professions, particularly in the medical, social and psychological domains. Competition does not seem to be experienced in relation to others within the interdisciplinary field, or toward those who are perceived as having a "solid" education. Instead, borderlines are drawn mainly between those who consider themselves to belong to the sexological landscape and have professional authority in the field, and those who strive to obtain this, i.e. the Non-professionals.

There is also further boundary work (Fournier, 2000; Light, 1988), that may be even more complex, i.e. the Pioneers' desire to continue belonging to the sexological landscape without being questioned or deprived of their professional authority based on long-term work. Another strain against boundaries occurs in the striving of women and younger people seeking more senior positions in the sexological associations. Additional cross-border activity takes place between the different scientific domains, where medical and psychosocial, psychodynamic or cognitive therapy models are pitted occasionally against each other. However, it is noteworthy that sexologists are more inclined to emphasize collaboration, transparency and respect between the different domains and rather close the borders against those who are not considered sufficiently competent, regardless of domain.

**Professional competence rather than profession?** Hence, is it possible classify sexologists as practitioners of a specific profession? Were we to base our evaluation on criteria such as systematic theory, professional authority, ethics, professional culture and societal sanctions (e.g.Johnson & Lindgren, 2001), it would be doubtful. Those working as sexologists belong to groups that are much too interdisciplinary, in order for common systematic theories to apply. In addition, some sexologists already belong to classic professions such as physicians; their main occupation and professional identity are already cemented, while others may be seen as semi-professionals such as social workers and nurses. As for specific ethical guidelines, they do not claim a major importance for sexology as a profession when there are already ethical standards in place for the various primary professions. Thus, they become important markers only in the boundary between qualified sexologists and those who lack specialized training. The authorization can be viewed in a similar manner; its most important function is to keep the Non-professionals away, since the majority of sexologists already have official licenses, post-graduate degrees or doctorates.

The concept of a profession is certainly relative (Wingfors, 2004:16), but perhaps professional competence is a summation that can describe a phase of the professionalization process that has appeared in this study. Indeed, the interviewees are very well educated and the majority have long research-based university
education behind them, even if sexology was not part of their basic curriculum. The interviews reveal a clear desire to achieve competence, professional standing and professionalism rather than an expressed desire to become a specific profession. In addition, the informants have expressed that trust and confidence are key concepts of the practitioner's legitimacy. As mentioned earlier, there is a tendency among several professions to speak of professionalism rather than a profession with a diminishing focus on formal qualifications and more on the actual professional practice and its situational and individual practitioners (Fransson, 2006).

At the same time there is an emerging ambivalence toward both the concept of profession and professionalisation, since there is uncertainty over the correct definition of a sexologist. The criteria for who gets to use the title are ongoing, both among sexologists themselves and among the public and those seeking help. Sexologists also maintain that sexological competence should meet the societal shifts that constantly occur where sexual norms and behavior patterns are concerned. Just as these concepts change and evolve, the process of sexologist as a profession is ongoing, and the criteria should continue to be discussed and analyzed.

Limitations

The study has several limitations, mainly in terms of selection and generalizability. Since the informants were all members of SFS, it is conceivable that there are non-member sexologists would provide different views of their profession. Moreover, it is difficult to know why not all members of the association volunteered for the study, and the specific information that is missed by utilizing this limited sample. If a sample had been solicited via a sexological association aimed at researchers in sexology, e.g. IASR, there may have been more informants with doctoral degrees. Despite these limitations, the interviews provided a lot of information about the sexologist's own images of the profession, all of which show common patterns, characteristics and groupings. Based on these results, new research questions can further deepen the knowledge in this area. An example would be a longitudinal study of current sexological students and their subsequent professional careers, in order to deepen our understanding of such professional studies. Perhaps new concepts would emerge which could be attributed to "Generation 1 and 2" in the continuation of the professionalization process.

References

Appendix

Interview Guide

**Theme: Professional background**
- Your own age, gender, civil status, sexual orientation – do you consider these factors important in your work?
- What is your educational background? Present title and occupation? How many years have you been working with sexology?
- Have you taken any sexology courses? How many ECTS credits, in that case?
- Do you have teaching/research experiences in sexology?
- Do you have an authorization as a clinical sexologist/sex counselor/sex educator or as a researcher in sexual science? Why/why not?

**Theme: Professional content and specialization**
- Do you work with sexological issues as an employee? Within which organization/administration? Or, do you have your own business?
- What kind of problems/dysfunctions/issues do you handle in your sexological work? Has there been a change over time?
- What patients/clients do you meet (e.g. men, women, young people, hetero-, bi-, homo-, transsexuals)? Change over time?
- Do you use any theoretical model? In that case, which one(s)?
- Do you have supervision/mentor? Do you follow any ethical guidelines? Is there a need for specific ones for sexology?

**Theme: Professional Network**
- Do you work alone or with a co-partner, or in a multi-professional team? Positive/negative aspects?
- Are you connected to a professional network/organization/association for sexologists? Is this important?
- How would you describe the professional atmosphere at your place of work?
- How would you describe your employers/patients/clients trust and confidence in your professional work?


