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Innovative psycho-social interventions aimed at reducing dysfunctional sexual beliefs

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Abstract

In a society where adolescents can easily access information through new technologies, sexual education has to keep up the pace. The present research used video materials combined with subsequent focus-groups to reduce dysfunctional sexual beliefs. The sample of 100 male participants was equally divided between the intervention and control groups. Participants' age ranged between 18 and 25 years, with a mean of 22. The results show a significant reduction of dysfunctional sexual beliefs one week after the intervention. This reduction was also evident six months later. The discussion focuses on the need to develop more accessible and effective intervention tools.
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1. Introduction

Psychology studies how the social environment shapes how we think, feel, and behave, at an individual or group level. While the society offers us models that are essential for our success as social beings, it may also be the source of dysfunctional beliefs that can harm our well being. Sexual beliefs and attitudes make no exception from this rule. The interaction between new factors of social influence and adolescent psychology can generate beliefs, attitudes, and behaviors that adults find hard to manage and understand

Dysfunctional sexual beliefs, whether determined by inadequate sexual education or conflicting cultural models, can cause "silent" suffering which is consumed privately and without proper awareness of its causes. Frequently, because adolescents cannot find proper information about their sexual issues, they are looking for answers on the Internet, which has a negative effect on dysfunctional beliefs because the most accessible information if often the least reliable. The main purpose of this paper is to align it to an approach that transforms a potential danger into an opportunity: If adolescent are using the Internet more than ever, why should we not develop Internet-based intervention tools in order to reduce dysfunctional sexual beliefs?

The spectacular development of new information technologies have opened up new avenues of research and intervention in therapy and counseling. First, the accessibility of communication through the Internet has made possible a better interaction between therapists and their clients. Even though initially many authors have focused on the negative consequences of these technologies, today the online interaction with the therapist is becoming more

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and more frequent.

Online therapy is defined as "any type of professional therapeutic interaction that makes use of the Internet to connect qualified mental health professionals and their clients" and is used either alone or in combination with face to face techniques (Rochlen, Zack, Speyer, 2004). Second, the development of specialized programs and games significantly increased then range of therapeutic approaches (e.g., computer-psychotherapy, video-clip therapy).

In the '80s there were several critical theories about the therapeutic effectiveness of videogames and, in spite of some promising results (Larose et al., 1989), this approach had to wait the new millennium for an increase in the researchers' interest. Now, several lines of research have demonstrated the effectiveness of therapeutic computer games (Bertolini & Nissim, 2002; Griffiths, 2004; Salonius-Pasternak, Gelfond, 2005; Umanski, Kosters, Verbeek, Schiller, 2008; Zelnick, 2005), and led to an online extension of the therapeutic intervention (Wilkinson, Ang, Dion, 2008). Regardless of the styles and types of games adopted by various authors, there seems to be a common result: the use of video game in psychotherapy has helped young patients to become more enthusiasts and cooperative in their relationship with the therapist (Ceranoglu, 2010).

The present paper will focus on video-clip interventions. Video-clip therapy offers the possibility to create countless video-clips that are more accessible than full movies and can be personalized by therapists according to their clients' needs. While existing movies and video-clips focus mainly on issues related to sexual hygiene, contraception, and anatomy, adolescents are also concerned by other problems and they look for answers on the internet, where the most accessible information is non-scientific and shaped by societal myths about sexuality. Although video clip based interventions are only in their first stages of development, their advantages and potential therapeutic, educational, or sociological could lead to a rapid expansion.

Video clip based interventions combine technology, educational methods, psychology, sociology, melotherapy and so on. Because many fields of research are involved in developing effective video-clip intervention, a pluri-inter-, and trans-disciplinary approach becomes essential. In world that undergoes a rapid process of transformation, concepts and theories follow the same path. Today we can only talk of a continuously adapting and changing dynamic system. Educational and therapeutic intervention methods are constrained by these post-modern societal realities and require a trans-disciplinar approach that should be as dynamic as individuals' need to adapt to a constantly changing society (Nicolescu, 1999).

Therapeutic video-clips accessed through the Internet can have several distinct advantages. First, given that sexual issues can easily trigger anxiety among clients and hamper the effectiveness of their communication with the therapist, online communication could provide a buffer against such reactions by encouraging therapeutic expression (Suler, 2004). Second, through Internet access the therapist can easily come in contact with clients regardless of mobility concerns (as is the case in the present study with participants from some rural areas). Third, in come contexts online communication people can transcend some constraints associated with actual presence and could relate to a more profound level (Suler, 2005).

It is important to note that our procedure was designed to counter some of the disadvantages associated with this kind of therapeutic intervention. For example, online interaction may miss important nonverbal and even verbal feedback, which is essential for the therapeutic progress (Alleman, 2002). In this respect, after both the individual and group intervention sessions we organized focus groups in which we gathered important information about how participants understood the message of the video-clips and offered them clarifications and guidance where and when was the case.

2. Method

2.1. Participants

Participants were 100 Romanians male volunteers whose age ranged between 18 and 25 years (the mean was 22). They were selected from a larger sample based on their high scores on a scale of dysfunctional sexual beliefs. Half of the participants were randomly assigned to the intervention group and the other half to the control group. Seventy

five percent of the participants reside in urban areas and 25% in rural areas. All of them had PCs with Internet access at home at home.

2.2. Procedure

Participants' dysfunctional sexual beliefs were measured three times: before the intervention, one week after the intervention, and six month after the intervention. The intervention was based on 20 educational-suggestive video clips. The suggestive dimension, which is used frequently in psychotherapy was employed with the purpose of increasing the intervention's effectiveness. Eighteen of the video clips were focused on the most frequent dysfunctional sexual beliefs identified before the intervention. Of the remaining two video clips, one was focused on increasing participants' self-esteem and the other one on elements of general sexual education. The intervention group was further divided into four subgroups, according the dominant type of dysfunctional beliefs. Each group watched 8 video clips, during a period of 8 weeks, with on intervention each week. Four video clips were watched individually and four in group. After each session, we conducted focus groups in which we collected information about the issues presented in the video clips and answered to the participants' questions. Each session lasted for one hour, with the first 30 minutes allocated for the video clips and the last 30 minutes for the focus groups.

2.3. Measures

Participants completed two questionnaires: (1) the Dysfunctional Attitudes Scale -A (DAS-A), an instrument developed by developed by Weissman&Beck(1978) in order to identify distorted beliefs and attitudes linked mainly to depression. It has 40 items and responses that range on a scale from 1 – completely disagree to 7 – completely agree. We used a Romanian adaptation of this scale (Macavei, 2002); (2) Distorted Opinions, Information and Beliefs about Sexuality (DOIBS), and instrument developed by Bălănean (2010) for the Romanian population. It has 40 items and responses range on a scale from 1 – completely disagree to 7 – completely agree.

We also collected information about the participants' socio-economic profile (e.g., residence, age, education).

3. Results

Table 1 presents the descriptive statistics for the three waves of data collection. To test whether the intervention had the predicted effects on participants' dysfunctional beliefs we subjected the data to a repeated measures general linear model with participants' scores on the three waves of data collection as the within subjects factor and participants' level of education and place of residence as the between subjects factors.

Table 1. Means and standard deviations of the dependent variables for the three waves of data collection (values in parentheses represent the control group).

	DOIBS		DAS	
	Mean	**SD**	**Mean**	**SD**
Before the intervention	4.06 (3.93)	.39 (.39)	3.11 (2.94)	.06 (.05)
One week after the intervention	3.20 (3.92)	.29 (.42)	2.86 (2.93)	.10 (.07)
Six months after the intervention	3.13 (3.89)	.31 (.36)	2.85 (2.91)	.10 (.06)

The analyses failed to identify any significant effects of the socio-demographical variables on dysfunctional beliefs scores but found significant within subjects effects for the intervention group. More specifically, compared with their initials scores (M_1 = 4.06), participants' DOIBS scores were significantly smaller one week (M_2 = 3.20, p < .001) and six months after the intervention (M_3 = 3.13, p < .001). There was no significant difference between the last two waves of data collection. In the control group no difference reached the significance threshold.

The situation was similar for participants DAS score: compared with their initials scores ($M_1 = 3.11$), participants' DAS scores were significantly smaller one week ($M_2 = 2.86$, $p < .001$) and six months after the intervention ($M_3 = 2.85$, $p < .001$). There was no significant difference between the last two waves of data collection. In the control group there was one significant difference between M_1 (2.94) and M_3 (2.91), $p < .001$.

To further refine our analyses we also conducted a repeated measures general linear model on the four DOIBS subscales. These subscales include items concerning beliefs related to erection and penis size (e.g., "my partener would appreciate me more if I would have a bigger penis"), masturbation (e.g., "Masturbation is a proof of weakness and lack of self control"), sexual guilt (e.g., "I am embarrassed by my sexual fantasies") and sexual misinformation (e.g., "I feel do not have adequate knowledge of sexual techniques"). The descriptive statistics are presented in Table 2.

Table 2. Means and standard deviations of the four DOIBS subscales for the three waves of data collection.

Subscales	Wave	Intervention group		Control	
		Mean	SD	Mean	SD
Erection and size	1	4.52	.48	4.35	.63
	2	3.20	.44	4.31	.66
	3	3.10	.43	4.34	.61
Masturbation	1	4.30	.08	3.80	.45
	2	3.48	.09	3.78	.45
	3	3.44	.09	3.79	.42
Guilt	1	3.29	.79	3.64	.79
	2	2.69	.62	3.66	.78
	3	2.68	.59	3.59	.76
Lack of information	1	3.55	.61	3.71	.75
	2	3.10	.53	3.72	.75
	3	3.02	.53	3.61	.76

The within subjects effects were significant for the intervention group. For all four subscales, compared with their initials scores, participants' subscales' scores were significantly smaller one week and six months after the intervention (all ps < .001). There was no significant difference between the last two waves of data collection. In the control group no difference reached the significance threshold.

4. Discussion

The present study, which is part o a larger research project, applied an innovative intervention (video-clips combined with subsequent focus groups) to young Romanians in order to reduce dysfunctional sexual beliefs. The results showed significant reduction in the predicted direction not only on the general scale but also on all of its four subscales. Moreover, it seems that the results generalized to more general dysfunctional beliefs, suggesting that the benefits of our interventions may be more widespread than expected.

We think that the success of this intervention can be explained by the fact that it largely acts on the causes of the dysfunctional sexual beliefs. That is, the intervention focuses on the lack of adequate knowledge of sexual issues, both quantitatively and qualitatively. Another factor may pertain to the anxiety generated by sexual problems, which determine individuals to avoid direct contact with a specialist. Our technique addresses this issue by putting individuals in contact with video materials that contain the same information they would have found from an expert.

The extension of the intervention's benefits to more general dysfunctional beliefs could be explained through both direct and indirect mechanisms. We speculate that the direct path is given by the rational-educational component of the intervention, which probably trained a healthy cognitive system that challenges dysfunctional beliefs in general. On the other hand, the indirect path means that participants' self-esteem was improved by the intervention and this could have had positive effects on the ego-related cognitions that are measured by the DAS. These findings encourage us to further test combinations of modern intervention techniques. We plan to expand on the content of these video clips and to improve their effectiveness based on participants' feedback. Another direction

of future development is to develop and test 3D video clips. Based on 3D experiments in computer-psychotherapy we expect that they could have a greater impact on the target beliefs, attitudes, and behaviors.

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