

AN OVERVIEW OF SEXUALITY IN CLINICAL PRACTICE

A Project

Presented to the faculty of the Division of Social Work  
California State University, Sacramento

Submitted in partial satisfaction of  
the requirements for the degree of

MASTER OF SOCIAL WORK

by

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SPRING  
2015

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Division of Social Work

Abstract  
of  
AN OVERVIEW OF SEXUALITY IN CLINICAL PRACTICE

by  
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This exploratory study examined the frequency and approach used by mental health care professionals to address sexuality in individual therapy. Using convenience-sampling clinicians (N=75) from a variety of disciplines completed an online questionnaire. Study findings, based on quantitative data, suggest that 36% to 64% of clinicians initiate a discussion of sexuality depending on the diagnosis of the client. When sexuality is addressed in the clinical practice setting eclectic therapeutic techniques are most frequently used. In addition, due to the diversity of the sample a comparison using the Sexuality in Practice Scales showed that clinicians with a background in social work were significantly less comfortable addressing sexuality than clinicians from other disciplines;  $t(54)=2.15, p=0.036$ .

\_\_\_\_\_, Committee Chair  
Teiahsha Bankhead, Ph.D., LCSW

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## ACKNOWLEDGEMENTS

It is with tremendous love and respect that we express our gratitude for the following individuals who provided inspiration, support and endless encouragement:

Partners

Parents

Family

Friends

Mentors

Teachers

Clients

&

Each Other

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## Chapter 1

### **Introduction**

Sexual health is fundamental to the physical and emotional health and well-being of individuals, couples and families, and to the social and economic development of communities and countries. When viewed affirmatively, sexual health encompasses the rights of all persons to have the knowledge and opportunity to pursue a safe and pleasurable sexual life. (WHO, 2010)

### **The Problem**

The human right to safe, healthy and pleasurable sexual expression has largely been forgotten by the field of social work. A thesis study done at California State University, Sacramento by a masters student in the Social Work Division included a qualitative review of course materials and Master of Social Work students' opinions found that while most students thought sexuality was relevant to competent social work practice the topic is largely neglected (Radecki, 2009). More specifically the study found that addressing sexual orientation and gender identity were most commonly covered, while the benefits of sexual pleasure, diversity of sexual expression and sexual difficulty or diagnosable dysfunction went completely ignored (Radecki, 2009).

The neglect of sexual expression in the field of social work can also be seen from a macro perspective in the report, Mental Health Services Act Programs 2013: Saving Lives, Saving Money, completed by The National Alliance on Mental Illness in California (NAMIC, 2013).

The programs funded by the MHSA are provided by the county and are designed

to aid individuals in the pursuit of mental health and wellbeing. In the 204 page report all the programs funded by the MHSA in California are described. The only mention of sexuality in all of the program descriptions are regarding the inclusion of the LGBTQ community and services for survivors of sexual abuse, trauma or exploitation. No program in the report mentions sexual expression, sexual dysfunction or sexual difficulty. It is also striking that the programs that do offer services for survivors of sexual abuse, trauma or exploitation are predominantly focused on these services only. Programs that were not specifically focused on sexual abuse, sexual trauma, and sexual exploitation for the most part did not mention sexuality even to establish inclusion of the LGBTQ community.

Sexuality is an aspect of every person's life. Information about sexual expression and help for those experiencing sexual dysfunction and difficulty should be a part of the human services landscape. Social work, a field that is rooted in social justice and the advocacy of the underrepresented, must fight for this issue. To continue to ignore the topic of sexual expression on the micro level in clinical practice, at the meso level in agency programs and at the macro level of policy advocacy would go against the values at the very core of this profession.

### **Background of the Problem**

Sexual health and sexual pleasure are human rights (WHO, 2010). Historically, their importance has been minimized especially within underserved and marginalized communities (Dunk, 2007). Mental health professionals, and specifically clinical social workers, must be sure to address these topics with clients in pursuit of the core value of

social justice. The way sexual health, pleasure, expression and orientation are addressed by licensed mental health practitioners should be governed more closely by the various government agencies that monitor and award these licenses. Unfortunately, an attitude of sex negativity has heavily influenced the treatment of sexual issues on a micro, meso and macro level (Goodwach, 2005).

The importance of an ethical and evidence based assessment of sexual health is affirmed by the prevalence of sexual dysfunctions. Within the context of this research study and the field of mental health in The United States sexual dysfunctions are primarily defined by the American Psychological Association's Diagnostic and Statistical Manual of Mental Disorders 5. Based on a study that used the results of a National Health and Social Life Survey with 1749 women and 1410 men aged 18-59 as a probability sample, it was predicted that sexual dysfunction affects 43% of women and 31% of men in the United States (Laumann, Paik & Rosen, 1999). Another study on the prevalence and severity of sexual dysfunctions as well as difficulties, that surveyed a sample of 37,921 heterosexual Flemish people reported that 47.7% of men and 49.2% of women experience at least one sexual difficulty or dysfunction with a moderate to severe level of impairment of the course of their lifetime (Hendrickx, Gijs & Enzlin, 2014).

According to the most recent statistics reported by the Bureau of Labor Statistics in 2012 there were 166,300 mental health counselors and marriage and family therapists 160,200 psychologists and 607,300 social workers practicing in the United States (U. S. Bureau of Labor Statistics, 2012). Of these professionals it is unknown what type or how much specialized training on the ethical treatment and assessment of sexual issues they

received. A ten-hour training on human sexuality is required to become a Licensed Clinical Social Worker in California (BBS, 2012). Although this training is not renewed in the biannual relicensing process it is the only specifically defined training that relates to the issue of sexuality (BBS, 2012).

The high prevalence of sexual dysfunctions, the lack of training on the importance of sexual health at the master level and practitioner discomfort are all issues that demand attention. With this exploratory study we hope to find out where growth and improvement are required in the practice of clinical social workers in individual therapy.

### **Statement of the Research Problem**

Sexual health and sexual pleasure are human rights. Unfortunately, honest dialogue concerning sexual health and sexual pleasure continues to remain taboo in our dominant culture (Eaklor, 2008). This has resulted in sexual health and pleasure being minimized in our society. Further, some sociosexual issues have received more attention than others. Dunk (2007) states “much of the literature relating to social work and sexuality explores working with sexual minorities and subsequently there is a dearth of research on the relevance of what [is] termed [as] everyday sexuality for social work practice and education” (p.136). The research problem is as follows: Little research exists that explores how social workers address sexuality in the context of individual therapy when the client’s primary concern is not related to sex.

**Purpose of the Study.** This projects aims to make a contribution to existing social work scholarship regarding human sexuality. In order to accomplish this, the project attempts to quantitatively assess the degree to which sexuality is explored in the

context of individual therapy. The survey instrument utilized for the purposes of this project takes into consideration the various theoretical orientations as well as the personal and professional influences that inform a social worker's practice regarding sexuality. It also considers various presenting reasons for receiving services and assesses knowledge and comfort regarding various sexual topics.

The survey also collects demographic information including the gender, sexual orientation, age, and ethnicity of the practitioner and explores the degree to which sexuality in the context of individual therapy is explored among those sub-populations. By providing a preliminary tool to quantitatively study sex positivity in the context of individual therapy, this study attempts to fill a gap in social work scholarship. Further, the findings of this study could have broader implications regarding how social work practitioners can improve the services provided to their clients. Clinical social workers must be sure to address sexuality with clients in pursuit of the core values of social justice. A thorough professional mental health assessment should include some level of inquiry into a client's sexual health.

**Theoretical Framework.** This study is based on the theoretical framework of sex positive feminism (Woodford, 2013; Glick, 2000; Kahs, 2015). A brief explanation of the sex positive movement follows. The sex positive movement originated from the identity politics of liberation movements that occurred in the 1950's and 1960's, and continued to gain traction and progress through the feminist and queer movements (Woodford, 2013; Glick, 2000). The movement emerged as a reaction to discourses of sexuality considered repressive (Kahs, 2015).



A sex-positive approach places emphasis on the aspects of sex that are rewarding, pleasurable, and nonprocreative (Williams, Prior, and Wegner, 2013). Additionally, the sex positive approach acknowledges the vast cultural diversity found in sexual practices which result in tremendous variation in personal meanings and preferences (Williams, Prior, and Wegner, 2013; Popovic, 2006). Sex-positivity entails openness, communication, and acceptance of differences related to sexuality and sexual behavior.

Consensual sexual activity viewed through the lens of sex-positivity is considered healthy. Further, sex-positivity is about choice; a person may participate in diverse sexual experiences or abstain completely from sex. In sum, “A sex positive approach is about allowing for a wide range of sexual expression that takes into account sexual identities, orientations, and behaviors; gender presentation; accessible health care and education, and multiple important dimensions of human diversity” (Williams, Prior & Wegner, 2013, p.273). The extent that the field of social work has been impacted by the sex positive perspective is unclear. What is known is that services provided through the lens of sex positivity could create a safe place for the discussion of client concerns with regards to sexuality and sexual functioning.

### **Definition of Terms**

Terminology in the context of this study is defined below:

**Sexuality:** A central aspect of the human experience. It is multifaceted and encompasses such dimensions as sex, gender roles and identities, sexual orientation, intimacy, pleasure, and reproduction. Sexuality experienced through a myriad of ways including fantasies, feelings, attitudes, thoughts, values, behaviors, practices, and

relationships. Not one experience of sexuality is the same, as not all of the dimensions of sexuality are expressed. Furthermore, one's experience of sexuality is influenced by the interaction of biological, psychological, social, cultural, political, religious, and spiritual factors (WHO, 2010).

**Sexual Health:** A condition of emotional, physical, psychological and intellectual sexual well being that is free of oppression, disease, stigma, pain and shame (WHO, 2010).

**Sexual Expression:** An individual's behaviors, thoughts and feelings related to their sexuality. This includes personal presentation of sexual identity, attitudes, desires and internal beliefs regarding sexuality. Sexual expression is shaped by many factors including by not limited to values, relationship dynamics, culture, religion, social constructs, governing bodies, and sexual partner's sexual expression (WHO, 2010, Silverberg, n.d.).

### **Assumptions**

Clinical social workers should honor the needs, choices, and experiences of every individual that they work with. In order to accomplish this social workers must have an open and accepting attitude with regards to diversity, including an individual's experience of sexuality. The field of social work has a responsibility to promote this climate of openness and acceptance.

### **Social Work Research Justification**

In the "Vision for the Future" section of The Surgeon General's Call to Action to Promote Sexual Health three areas are identified that require attention, "increasing

awareness, implementing and strengthening interventions, and expanding the research base” (The Surgeon General’s Call to Action to Promote Sexual Health, 2001). The call for more research in the field of human sexuality is outlined and specifically include need to, “Expand evaluation efforts for community, school and clinic based interventions that address sexual health and responsibility” (The Surgeon General’s Call to Action to Promote Sexual Health, 2001). The field of social work has not fully responded to this call. Regarding sexuality it is unclear where our strengths and weaknesses lie, so a path toward improvement is almost certainly found in increasing scholarly research in this area.

### **Study Limitations**

This research project is a descriptive, exploratory study that, aims to investigate how clinical social workers address sexuality in the context of individual therapy. This study does not focus on the efficacy of specific treatment methods, the impact of the therapeutic setting or how a clinician’s experience level or type influences the handling of sexual expression. Issues related to sexuality that did not directly fall under the category of sexual expression, such as sexual trauma and sexual orientation, are also not the focus of this study. Due to these limitations this study only endeavors to highlight the importance of more research on sexual expression and emphasize the importance of these issues.

### **Statement of Collaboration**

This exploratory study was made possible by the collaborative efforts of Masters of Social Work students, Miriam Yelton and Natalie Delfin. This collaborative study

included the distribution of an online questionnaire to social work clinicians to explore how clinical social workers address sexuality within the context of individual therapy. Upon completion of data collection, the student worked in conjunction to enter and analyze the data through the Statistical Package for the Social Sciences (SPSS) program. The written portion of this study was made possible by the concerted effort of the student researchers and was overseen and guided by Dr. Teiahsha Bankhead, the students' Thesis Advisor.

## Chapter 2

### **Literature Review**

This chapter will discuss sexuality and social work by evaluating social work scholarship and education. It will explore the impact that sexual well-being has on dimensions such as mental and physical health. It will examine social work practitioners' attitudes towards addressing topics of sexual concern with clients. The researchers will also provide the reader with an overview of traditional models used within sex therapy. Finally, this chapter will conclude with a discussion regarding the future of sex therapy.

### **Social Work Research & Sexuality**

“Much of the literature relating to social work and sexuality explores working with sexual minorities...there is a dearth of research on the relevance of what [is] termed everyday sexuality for social work practice and education” (Dunk, 2007, p. 136).

There has been an increase of interest in sexuality in social work scholarship and research in the past decade (Dunk, 2007; Chonody, Woodford, Brennan, Newman, and Wang, 2014; Chonody, Woodford, Smith, and Silverchanz, 2013; Scherrer & Woodford, 2013; Fredriksen-Goldsen, Woodford, Luke, and Gutierrez, 2011; Leech & Trotter, 2003; Dunk, 2007). Examples of this include discussing sexuality in the context of couples therapy (Bulow, 2009; Caplan, 2008), assessments of social work faculty and students' attitudes towards sexual minorities (Chonody, et al., 2014; Chonody, et al., 2013) research assessing content and curriculum concerning sexuality in educational settings, (Scherrer & Woodford, 2013; Fredriksen-Goldsen, et al., 2011) and articles promoting specific practices for the theorizing of sexuality (Leech & Trotter, 2003; Dunk, 2007).

However, the topic of sexuality is typically discussed in relation to alternative sexual identities to heterosexuality (Rowntree, 2014). Less research is concerned with how social work practitioners address sexual topics with individual clients who are not seeking services specific to concerns related to sexuality (Dunk, 2007).

### **Sexuality, Social Work & Education**

“Knowledge about everyday sexuality is vital to social workers as they deal with a variety of clients faced with the increasing complexities brought about by late-modernity” (Dunk, 2007, p. 136).

MSW programs are meant to prepare future practitioners for advanced, autonomous, multi-level practice with vulnerable life-conditions (Radeki, 2009). A review of the accreditation standards of the Council of Social Work Education (CSWE) reveals that curriculum pertaining to sexuality is not required in Masters of Social Work (MSW) programs (CSWE, 2008). Rather, the standards stress that professionals must practice with cultural competency when addressing concerns regarding sexuality and sexual orientation (Timm, 2009). Thus, the curriculum of social work programs often does not prepare future practitioners to address topics of sexual nature with their clients.

This point is illustrated by Radeki’s (2009) exploratory study that utilized a convenience sample of 112 MSW students from California State University, Sacramento. Students were asked to complete a questionnaire that examined the extent to which sexuality was covered in social work foundational courses. Direct practice courses in particular are meant to provide students with the knowledge, values, and skills to work in clinical practice. Radeki found that less than 50% of respondents stated that sexuality was

discussed in their direct practice courses.

Fredriksen-Goldensen and colleagues' research examines the level of support for an increase in educational content related to working with the LGBT community. The research, which focus on social work faculty in the United States and Canada, is more generalizable to a larger population (Fredriksen-Goldensen et al., 2011). In their work, the researchers obtained data from a web-based survey of 175 American and 152 Canadian Masters in Social Work program faculty randomly selected from a sampling frame constructed from the faculty lists of school websites. Their findings suggest that there is support surrounding an increase in curriculum content related to sexuality, sexual identity, and sexual orientation among the social work faculty.

Additionally, the model of cultural competency may be an inadequate approach in the face of the complexity of sexuality. Cultural competency refers to a set of congruent policies, behaviors, and attitudes that all professionals use to work effectively in cross-cultural contexts (NASW, as cited in NASW, 2001). It often involves learning to identify and respond to sets of traits that are specific to each culture (Tervalon and Murray Garcia as cited in, Hunt, 2001). Essentially, cultural competency emphasizes fostering a knowledge base with respect to different cultural groups (Hohman, 2013).

However, cultural competency's utility in promoting sensitivity to cultural differences is limited. It is impossible to know exactly how the complex intersections of race, gender, class, age, and sexual orientation, influence each individual's identity and cultural experience (Hohman, 2013). Furthermore, the lenses from which we view our clients with are influenced by our own experiences and bias. Hence, one's knowledge is

truly limited when it comes to knowing another's culture. The same can be said for sexuality, as it is expressed and experienced differently by each individual (WHO, 2014).

Perhaps the model of cultural humility is a more appropriate approach for understanding complex human dimensions such as sexuality (Hohman, 2013; Hunt, 2001). Cultural humility encourages a lifelong process of self-critique and reflection. It requires a practitioner to understand that embedded in each interaction is the practitioner's own assumptions and beliefs regarding the clinical encounter (O'Connor as cited in, Hunt, 2001). Through cultural humility the practitioner is "encouraged to develop a respectful partnership with each patient. . . , exploring similarities and differences between his own and each patient's priorities, goals, and capacities" (Tervalon and Murray Garcia as cited in, Hunt, 2001, p. 135). Cultural humility encourages practitioners to understand that they will never be an expert on any population. Each interaction with each client should take this into consideration.

### **Sexual Health: Mental & Physical Health Implications**

Sexual health is fundamental to the physical and emotional health and well-being of individuals, couples and families, and to the social and economic development of communities and countries. Sexual health, when viewed affirmatively, encompasses the rights of all persons to have the knowledge and opportunity to pursue a safe and threat-free sexual life. However, the ability of men and women to achieve sexual health and well-being depends on their access to comprehensive good-quality information about sex and sexuality, knowledge about the risks they face and their vulnerability to the adverse consequences of



sexual activity, their access to sexual health care, and an environment that affirms and promotes sexual health. (WHO, 2010)

Sexual health is imperative to the emotional and physical health and well-being of not only individuals, but couples (WHO, 2010; Timm, 2009). Research has shown that higher sexual satisfaction is found to be associated with fewer mental health issues (Frohlich & Meston, 2002; Tower & Krasner, 2006; Holmberg, Blair, & Phillips, 2010). Sexual health has been found to have a positive relationship with happiness and wellbeing (Laumann, Palk, Glasser, Kang, Wang, Levinson, Moreira, Nicolosi, & Gingell, 2006; Woodford, 2013). In the context of relationships, there is a strong link between sexual satisfaction and aspects of relational well-being (Sprecher, 2002, Byers; Demmons, Lawrence, 1998; Hinchliff & Meryn, 2004; Holmberg, Blair, & Phillips, 2010).

Sexual health is linked with physical health, as research has shown that there are several positive physical outcomes related to positive sexual behavior (Lefkowitz & Vasilenko, 2014; Charnetski & Brennan, 2004; Brody, 2006; Leitzman, Platz, Stampfer, Willet, & Giovannucci, 2004; Ebrahim, May, Shlomo, McCarron, Frankel, Yarnell, & Smith, 2002). For example, higher frequencies of sexual intercourse are linked to improved immune functioning (Charnetski & Brennan, 2004), lower levels of stress (Brody, 2006), reduced risk of early prostate cancer (Leitzman, Platz, Stampfer, Willet, & Giovannucci, 2004), and protection against coronary disease (Ebrahim, May, Shlomo, McCarron, Frankel, Yarnell, & Smith, 2002). Thus, the promotion of sexual health has implications for both the mind and body.

### **Sexuality & Pleasure as a Fundamental Human Right**

Sexuality is an integral part of human life. It carries the awesome potential to create new life. It can foster intimacy and bonding as well as shared pleasure in our relationships. It fulfills a number of personal and social needs and we value the sexual part of being for the pleasures and benefits it affords us...[but] to enjoy the important benefits of sexuality...it is necessary for individuals to be sexually healthy, to behave responsibly, and to have a supportive environment. (The Surgeon General's Call to Action To Promote Sexual Health, 2001)

Sexual rights are universal human rights. These rights are based on the dignity, equality, and the inherent freedom of all individuals (World Association for Sexual Health, 2014). Sexual rights can only be fully realized with the ability to understand the risks, responsibilities, and outcomes of sexual actions (Surgeon General's Call to Action to Promote Sexual Health, 2001). This ability can only be fostered in an environment that promotes an approach to sexuality that is both positive and respectful (WHO, 2014). Thus, communities have a responsibility to provide access to education that is developmentally and culturally appropriate, as well as sexual health counseling (Surgeon General's Call to Action to Promote Sexual Health, 2001).

### **NASW Code of Ethics**

“Social workers believe that the attainment of basic human rights require positive action by individuals, communities, nations, and international groups, as well as a clear duty to not inhibit those rights” (Riechert, 2003, p. 76).

The promotion of a positive and respectful approach to sexuality and sexual

relationships is in alignment with the National Association of Social Workers (NASW) Code of Ethics (2008). Regarding cultural competency and social diversity, social workers should pursue education about and strive to understand the nature of social diversity and oppression in respect to areas such as race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, and age (NASW, 2008). Although sexual expression is not included in those dimensions mentioned in the Code of Ethics, it is easy to see how it is in alignment to social work's values.

Furthermore, the preamble to the Code of Ethic states “the primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people” (NASW, 2008). If sexual health is related to both mental and physical health then providing opportunities to discuss sexuality in therapy should be standard practice.

### **History of Sex Therapy: The Origin of Practitioner Attitudes**

“Sex therapy refers to a multimodal therapeutic approach designed to improve sexual functioning. Sex therapy rests on the assumption that sexual performance problems are caused by a combination of lack of knowledge, misinformation, and faulty learning” (American Psychological Association, 2000).

The history of sexuality in general practice and sex therapy, as well as modern models and values, influence practitioner attitudes and practice (Nelson, 2004; Meana, Hall & Binik 2014). Aside from sex therapy, most other therapeutic models will neglect the importance of sexual health so that it is absent from the treatment of clients (Denman, 2004). Sex therapy has been the specialization within the field of mental health services

that focuses on sexual and marital dysfunction as described in The Diagnostic and Statistical Manual of Mental Disorders (American Psychological Association, 2013).

Three major sex therapy models have shaped how modern practitioners will view and address sexuality in practice (Goodwach, 2005). In order to understand how sexuality is addressed in practice, the history of the methodology must be identified and understood.

### **Models in Sex Therapy**

Any approach to the study of human sexuality that sets biology and social behavior in competition, or that stresses only one dimension to the neglect of the other, is counterproductive. It is futile to study human behavioral systems without integrating all significant levels of causation. Hence our goal ought to be an integration of all relevant systems and all relevant disciplines involved in sexual and reproductive functioning. (Rossi, 1994, p. 4)

Three influential models are the Cognitive Behavioral Model, the Medical Model and the Biopsychosocial or Systems Model. Each model attempts to address sexual dysfunction using a different framework and methodology. The Cognitive Behavioral Model focuses on how an individual's thoughts affects their behavior and vice versa, suggesting that if thoughts can be changed behavior will follow. The Medical Model focuses on sexual dysfunction as a physical illness, uninfluenced by the individual's mind and culture. The last model and the most prevalently is the Biopsychosocial or Systems Model which provides a framework that considers the entire individual including numerous internal and external factors that may affect sexual dysfunction (Goodwach, 2005).

### **The Cognitive Behavioral Model**

“Masters’ and Johnson’s work took place in a milieu of freedom and permissiveness, a result of the sexual liberation of the late sixties, with its emphasis on spontaneity, sensuality and rejection of restrictive inhibitions” (Goodwach, 2005, p.157).

The cognitive behavioral model in the field of sex therapy is rooted in the work of Masters and Johnson (Goodwach, 2005). They believed that an unsatisfactory sex life was the root of marital problems and that sexual satisfaction would lead to the resolution of other conflicts (Masters & Johnson, 1970). Using this model, sex therapists address dysfunction by treating the couple together. Dysfunction in a relationship is the responsibility of both partners and the relationship is the true patient. Masters and Johnson also believed that Dual-Sex Therapy Teams consisting of a male and female therapist were most effective for the treatment of relationships experiencing dysfunction. Behavioral therapists seek to increase or decrease a behavior by using methods that increase partner communication and desensitize or sensitize the individual to the behavior (Masters & Johnson, 1970).

Behavioral assessment divides sexual dysfunction into two categories of desired sexual response and undesired sexual response as dictated by The Diagnostic and Statistical Manual of Mental Disorders, which critics argue is an oversimplification (Fischer & Gochros, 1977). Behavioral interventions are also divided into two categories based on whether the goal of the treatment is to either increase desired sexual response or decrease undesired sexual response (Fischer & Gochros, 1977). Methods intended to increase desired behavior include education, manipulation of stimuli, positive

reinforcement, desensitization, modeling and self-exploration through masturbation (Fischer & Gochros, 1977). Whereas methods designed to do the opposite include trained avoidance, virtualization of negative outcomes, and aversive conditioning (Fischer & Gochros, 1977). Methods are used in combination to decrease one behavior while increasing another.

The behavioral model is also criticized for its certainty of a sexual norm (Bhugra, Popelyuk & McMullen, 2010). Fischer and Gochros suggested a guideline in the text Handbook of Behavioral Therapy with Sexual Problems in 1977, just seven years after Masters and Johnson original work was published. The guidelines suggest the importance of questioning labels including “mental illness” and “sexual deviance” while considering the context of the individual including culture, class and other external influences. In addition they questioned the efficacy of using aversive techniques for behavior modification which could potentially cause negative associations and or trauma. The belief in a universal sexual norm continues to be perpetuated by practitioners today (Bhugra, Popelyuk & McMullen, 2010).

### **The Medical Model**

The best scientific evidence of efficacy has been obtained for purely biological treatments. Some scientific evidence of efficacy exists in relation to cognitive behaviorally based sex therapies but very little scientific evidence of efficacy has been gathered in relation to all other treatment. The quality of evidence also varies between different conditions. (Denman, 2004, p. 315)

The medical model is built upon seven assumptions of human sexuality that are

similar to those used by medical doctors in the treatment of the body. By using the same model to treat sexual dysfunction as physical illness many important factors are not considered including individual psychology, macro influences and cultural norms. The seven assumptions used in this model include mind-body dualism, the objective universal body, naturalism, universalized bodily sexuality, individualism, biological reductionism, reified diseases (Tiefer, 1996).

1. Mind-body dualism is the concept that the mind and body are independent from one another and can be treated separately (Tiefer, 1996). The separation of the mind and body has led to the belief that sexual problems identified by physical symptoms will be cured by treating the body and discounting any influence of the mind. Furthermore, the study of human sexuality from a purely physiological perspective reinforces the idea that there is a normal or correct way that sexuality should be expressed as dictated by the body (Denman, 2004; Wylie, 1995).

2. The concept of the objective universal body is that the human body can be fully understood using scientific knowledge, which is impervious to the influence of culture and psychology. It is impossible to comprehend an individual's sexuality without an understanding of the world it has developed within (Tiefer, 1996).

3. Naturalism is the concept that human sexuality can be understood through the study of mammalian mating behaviors. The science of sex or sexology is built on a foundation of information obtained through the study of animals, which presents sex as a function of the body, and sexual behaviors as a product of natural selection (Tiefer, 1996; Katchadourian, 1979). Naturalism does not account for the complexity that human

psychology brings to the act of sex.

4. Universalized bodily sexuality suggests that there is one true and correct version of sexual expression. The work of researchers Masters and Johnson focused on the 'normal' physical sexual response and is an example of a universalized sexual norm based on the medical model (Tiefer, 1996).

5. Individualism is the concept that disease, or in the case of sexuality, dysfunction, exists within the individual patient. Individualism rejects Masters and Johnsons idea that dysfunction exists between the two people who experience it together (Tiefer, 1996; Master & Johnson, 1970).

6. Biological reductionism is the concept that disease (or sexual dysfunction) can best be understood by researching the human's basic biological components on the molecular level (Tiefer, 1996).

7. The reification concept assumes that in the case of a sexual dysfunction there is a discrete biological issue that should be treatable regardless of cultural or social factors. Then, if medical intervention is unsuccessful it is not due to an ineffective treatment or an inaccurate diagnosis, but is the fault of the patient (Tiefer, 1996).

In short, the medical model suggests that the treatment of sexual dysfunction should be similar to the treatment of physical disease. Proponents of the medical model point to the success of treatments such as Viagra and surgical intervention to treat vaginal discomfort (Denmen, 2004). However, critics of the medical model argue that the treatment of sexual dysfunction is more complex than the treatment of physical disease because of a patient's psychology and the influence of culture (Wylie, 1995; Tiefer,



1996). If a client comes to a therapist with a complaint regarding their sexual health, the medical model and the DSM dictate that the therapist should first refer the client to a medical doctor to rule out physical causes of the dysfunction (Wylie, 1995; Tiefer, 1996).

If a practitioner chooses to treat the client for the dysfunction they must diagnose the client using the DSM in order to be reimbursed for their services by an insurance company (Doan, 2004).

The medical model fails to acknowledge that sex and sexual dysfunction occurs between partners; furthermore, the dysfunctions in the DSM, utilized in conjunction with the medical model, fail to differentiate between sex and intercourse (Doan, 2004). The medicalization of sexuality and the treatment of sexual dysfunction have affected practitioner attitudes and behavior (Tiefer, 1996). Essentially, the medical model has influenced practitioners to associate sexual concerns with physical health rather than mental health.

### **The Systemic or Biopsychosocial Model**

Adopting a consistently biopsychosocial approach amounts to saying that it is always an error to neglect any one of the biological or the social or the psychological domains. The biopsychosocial approach can be viewed as a progressive narrowing of focus from statements of the most general nature about human affairs to statements of a highly individual and specific kind. (Denman, 2004, p.2)

The most widely accepted framework for human sexuality is the systemic or biopsychosocial model (Denman, 2004). George L. Engel first critiqued the biomedical

model when he introduced the biopsychosocial model in *The Clinical Application of The Biopsychosocial Model* (Engel, 1980). Engel criticizes the biomedical model for what is neglected when using the framework. He emphasizes the importance of system theory and the practitioner's understanding of the whole client. In Eros and Caritas: A Biopsychosocial Approach to Human Sexuality and Reproduction, Alice S. Rossi explores how this model is especially illuminating to the understanding of sexuality (Rossi, 1994).

Using the biopsychosocial model, sex therapists have a framework that acknowledges countless factors of sexual dysfunction but provides an organizational structure. Biological, sociological, and psychological factors are identified as well as systemic levels including the micro, meso and macro (Denman, 2004). Unlike the Medical or Cognitive Behavioral Model Systems and Biopsychosocial models consider “the experiential with the functional, and address the relationship between intimacy and sexuality” (Goodman, 2005). Using this framework practitioners can take a more holistic and culturally competent approach to the treatment of sexuality (Sungur & Gündünz, 2014).

### **The PLISSIT Model**

“The PLISSIT model is a practical and useful reminder for all therapists that not every sexual problem requires formalized training as a sex therapist.” (Timm, 2009, p.19)

Although originally developed for use in Medical Settings, the PLISSIT model may prove as a useful framework in which to conceptualize clients' concerns regarding sexuality (Annon as cited in Dunk, 2007; Timm, 2009). PLISSIT refers to four levels of intervention: Permission, Limited Information, Specific Suggestions, and Intensive

therapy (Annon as cited in Timm, 2009). It is a graduated system of therapeutic interventions in which sexual concerns within the scope of the practitioners' practice are identified and treated quickly. Those cases that are identified as being more difficult are referred out to more specialized help as needed.

According to Timm (2009), the model is a reminder that not every sexual concern requires a formally trained sex therapist. Rather, most cases will employ the first three levels of therapeutic interventions which are described briefly as follows.

“Permission” is the first level of intervention and refers to the idea that clients need to be given permission by the practitioner to discuss their sexuality (Timm, 2009). This involves the therapists asking a few simple questions about their sexuality and/or sexual well-being. Asking questions about sexuality in an initial assessment conveys that sexuality is important and shows the practitioner’s comfort level with regards to sexual issues.

The PLISSIT model’s second level of intervention is “Limited Information.” The premise behind this level of intervention is that clients often only need basic sexuality information to improve sexual functioning. It provides an opportunity for the practitioner to correct myths and misinformation, as many clients may lack knowledge of basic sexual anatomy and function (Timm, 2009).

The third level of intervention is “Specific Suggestions.” Often clients may desire specific recommendations about what they can do to address the sexual concern. Timm (2009) recommends psychoeducation and bibliotherapy as being helpful for the practitioner who wishes to assist the client but feels that “treatment” is beyond their scope

of practice.

The fourth and final level of intervention is “Intensive Therapy.” If the first three levels of intervention prove unsuccessful, referral to a trained sex therapist may be needed (Timm, 2009). A sex therapist can provide specialized treatment to clients whose cases are complicated by complex life issues, comorbid disorders, sexual trauma, and a host of other socio-sexual issues.

### **Focus on Dysfunction**

“Normal and abnormal behaviors are defined and differentiated by the society and culture, with the culture defining deviance—what is “abnormal” versus what merely contravenes the norms of society” (Bhugra, Popelyuk & McMullen, 2010, p. 242).

Each of the major frameworks used in the field of sex therapy focus on sexual dysfunction as defined by The Diagnostic and Statistical Manual. The DSM identifies dysfunction using the heterosexual norm presented by Masters and Johnson among other researchers (Goodwach, 2005). These norms are also based on surveys conducted predominantly in western societies, excluding much of the world, in addition, the accuracy of these surveys is highly questionable because of the sensitivity of the topic and participants’ tendency to report inaccurately (Bhugra, Popelyuk & McMullen, 2010). Any model that uses the DSM as a guide to address sexual dysfunction will have an inherently flawed attitude toward sexuality because it does not consider political or cultural influences on the norm (Popovic, 2006). Further the DSM-5 has excluded any discussion of non-penetrative sex as it relates to sexual dysfunction (Sungur & Gündünz, 2014).

In the fifth edition of the DSM some wording has been changed to prevent stigmatizing diagnosis and or labeling (Sungur & Gündünz, 2014). For example, all sexual dysfunctions in the DSM-5 require “the problem causes clinically significant distress in the individual” (American Psychological Association, 2013). Another noteworthy change in the DSM-5 is that anxiety and fear regarding pain surrounding sex has replaced an emphasis on dysfunction as an impediment to vaginal intercourse.

The behavioral model, medical model, and biopsychosocial model attempt to identify solutions to the dysfunctions described in the DSM, but none allow a closer look at the way dysfunction is identified (Popovic, 2006). Medicalized and standardized sex has been regimented, leaving little room for ‘erotic imagination’ (Denman, 2004). Erotic imagination refers to a professional’s ability to use their imagination to both understand sexuality as well as create methods of treatment. Using erotic imagination as well as an open mind to understand sexual dysfunction may be a key to competent treatment regarding sexuality (Sungur & Gündünz, 2014; Denman, 2004).

### **The Future of Sex Therapy**

The discipline is clearly undergoing a period of existential self-reflection that stands in stark contrast to its self-assured origins. The heady early days of sex therapy held promise of targeted interventions for clearly defined sexual problems with easily assessed outcome. (Meana, Hall, & Binik, 2014)

The future of sex therapy is unclear as the understanding of sexuality becomes more inclusive and complex. Perhaps the marginalization of sex therapy was a product of society's discomfort with sexuality. It is possible as this discomfort eases, that sex therapy

will be absorbed into general practice as “sex therapy’s claims to specialization may be exaggerated and ultimately damaging to the integrated treatment of sexual dysfunction. In fact, sex therapy does not have a unified underlying theory, a unique set of practices, or an empirically demonstrated efficacious treatment outcome,”(Binik & Meana, 2009) though losing the specialization of sex therapy could potentially damage the progression of research and treatment as researchers and therapists lose expertise (Binik & Meana, 2009). If sex therapy is absorbed, then it becomes the responsibility of all therapists to become culturally competent with regards to sexuality.

General practitioners who address sexuality may find that it increases their competence; discourse regarding an individual’s sexual health can be used to illuminate other aspects that are difficult to discuss (Schnarch, 1991). Practitioners will need to gain a better understanding of sexual diversity and question the definition of dysfunction presented in the DSM (Popovic, 2006). As practitioners continue to grow their understanding of sexuality, it may become apparent that labels and definitions are too numerous to be helpful. Thus, the use of spectrums and unique treatments for each client will become standard practice (Popovic, 2006; Bobele, 2004). The move toward fluidity can be observed in the shift from specific labels in the LGBTQ community to the single ambiguous label Queer (Gamson, 1995). By transitioning to a more inclusive label othering and identity based grouping is less specific and rigid (Gamson, 1995).

### **Alternative Models Integrating Sexuality**

Some therapies have ignored sex or treated it only as an afterthought or even a nuisance... These therapies tend neither to consider sexual difficulties nor to

theorize them. The extent to which this deficiency weakens them as therapies will depend on whether it is believed that sexuality is a pervasive feature of human experience that can, in consequence, never be ignored. (Denman, 2004, pp. 308)

If sex therapy is absorbed into mainstream practice, then models that fully incorporate sexuality will be important to competent practice. It will be important that the models are evidence based and not tinged by current political and social beliefs as they have been in the past (Howard, 2010).

The sex positive movement of the 1960's and 1970's presented sexuality as a positive and emphasized the importance of pleasure and sex education (Goodwach, 2005; Meana, Hall and Binik, 2014; Williams, Prior, and Wegner, 2013). During the movement, mainstream social work scholarship experienced an increased interest in sexuality (Scherrer & Woodford, 2013). Content concerning sexuality is not readily available in mainstream sources of information (Scherrer & Woodford, 2013). A "sex-positive" approach may also be considered when addressing socio-sexual concerns.

A sex positive approach places emphasis on the rewarding, pleasurable, and non-procreative aspects of sex (Williams, Prior, and Wegner, 2013) and acknowledges the cultural diversity in sexual practices (Popovic, 2006). It means, "being open, communicative, and accepting of individuals' differences related to sexuality and sexual behavior" (Williams, Prior, and Wegner, 2013, p. 273). Sex positivity takes into consideration that each person is unique, especially when taking into account the complex intersectionality among the dimensions of diversity. Since sexuality is linked to these dimensions, sexuality in itself is unique to each person. Essentially, the sex positive

approach advocates that the topic of sex be discussed in a way that it is respectful, open, and non judgmental (Williams, Prior, and Wegner, 2013).

Positive Psychology is a new field that encompasses the study of positive characteristics and emotions (Encyclopedia of Positive Psychology, 2009). Proponents of positive psychology argue that researching dysfunction will not lead to understanding function and instead psychologists should focus on what makes individuals functional and successful. Specifically within the field of sex therapy the focus of research should be on marital happiness and sexual health instead of unhappiness and dysfunction (Encyclopedia of Positive Psychology, 2009). The focus on happiness and success should also apply to the evaluation methods of public programs that strive to decrease dysfunction within couples (Fincham as cited in Encyclopedia of Positive Psychology, 2009). Similarly, sex therapy methods should not seek to only decrease dysfunction but also promote satisfaction and pleasure.

Another technique born out of the Positive Psychology is Well-Being Therapy. The structure of this model is similar to the biopsychosocial model in that it attempts to engage the whole person yet is different in how it uses the positive psychology perspective, which focuses on strengths. (Ryff as cited in the Encyclopedia of Positive Psychology, 2009). These factors include “psychological well-being, encompassing six dimensions: autonomy; personal growth; environmental mastery; purpose of life; positive relations and self-acceptance” (Ryff as cited in the Encyclopedia of Positive Psychology, 2009). Well-Being Therapy could be helpful in shifting the treatment of sexuality from dysfunction focused to pleasure and satisfaction focused (Rosen & Bachman, 2008). As



the focus of treatment shift and the labels of sexual dysfunction are eliminated plasticity in practice will become more important (White, 1995; Howard, 2010).

Narrative therapy techniques may provide flexibility to both the practitioner and the client that are needed in the future (White, 1995; Goodwach, 2005). Narrative therapy techniques could allow a client to separate their sexuality from the social and cultural constructs that have shaped their identity and experience (Blanton & Vandergriff-Avery, 2001). The Eclectic Narrative Approach to sex therapy includes four major techniques, externalizing problems, identifying prescribed stories, identifying preferred stories, exploring restraints and finally generating unique outcomes (Doan, 2004). Flexibility, wellbeing and positivity are the pillars of modern models of sex therapy which may eventually shift into a general framework that is all inclusive (Blanton & Vandergriff-Avery, 2001; Jones, Meneses de Silva & Soloski, 2011, pp.129). One version of such a model is The Sexological Systems Model which takes the biopsychosocial model and incorporates sexuality. This is one example from a group of emerging models that account for the importance of sexual health and pleasure. Models such as these will be central to the integration of sex therapy into the general practice of therapists (Binik & Meana, 2009).

### **Conclusion**

...It seems evident that values about sexuality within social work are, to date, relatively unexplored. Further it can be argued that compartmentalizing sexuality into specialized areas of practice has acted to eclipse the need for sexuality to be approached as an everyday characteristic of the self. Were sexuality to be seen as a human attribute, it would therefore be of central concern to a profession whose

work centers around people. (Dunk, 2007, p.137 )

Sexuality is an essential part of the human experience (Jones, Menses de Silva, and Soloski, 2011). Sexual development occurs across one's lifespan and is contingent upon the satisfaction of basic human needs such as the desire for intimacy, pleasure, tenderness and love. It is a product of the interaction between individual and social structures.

Additionally, there is a dearth of research assessing practitioner attitudes when it comes to addressing sexual topics with their clients (Dunk, 2007). A therapist's comfort level with sexual issues can influence their willingness to discuss them with their client. It follows that if a therapist is comfortable with the topic of sexuality, they are more likely to ask about it; and conversely, if a therapist is uncomfortable about sexuality, they are less likely to ask about it (Timm, 2009).

Practitioner discomfort, and the sex negativity that follows, may be perpetuated by the discipline of social work itself (Jeyasingham, 2008). Often, when sexuality is discussed, it is in terms of sex-negativity, rather than sex-positivity. It has been suggested that this attitude is influenced by the stigmatizing contexts that social work occurs within, such as working with individuals who are victims of sexual violence, contexts where discourse regarding sex for pleasure is inappropriate. Thus, "social work's professional knowledge about sex...is organized around terms quite different from desire, pleasure or erotics" (Jeyasingham, 2008, p.141). It is unclear if this could be applied to Licensed Clinical Social Workers in the private practice setting.

Another factor that may impact the likelihood of a dialog concerning sexuality is

the question of setting and suitability. It may be seen as inappropriate to bring up sexual health with a client whose main concern is not related to sexuality. Psychosexual exploration may also only seem appropriate when working with individuals of marginalized or minority populations, for example, studies that concern gay, lesbian, bisexual, transgender, and queer (GLBTIQ) client populations. In social work, “less attention has been given to how all actors, regardless of sexual identity, individually construct or negotiate their sexuality in relation to prevalent sexual norms” (Dunk, 2007, p.136). Thus, it is integral that sexuality is addressed with all clients regardless of their sexual orientation or primary concern.

Research, education, influential frameworks, and practitioner attitudes shape the way sexuality and sexual health are addressed in practice today. The fundamental models of Cognitive Behavioral Model, the Medical Model and the Biopsychosocial or Systems Model all inform the practice of sex therapy, in theory. Regarding the current climate of practice, prevalence and adherence to these models, let alone a basic assessment of sexuality in individual therapy is unknown.

The promotion of sexual health is imperative for individual, interpersonal, and societal well being (World Association for Sexual Health [WAS], 2012). If practitioners fail to address sexuality the task becomes the responsibility of the client. However, patients may refrain from initiating discussion about sexual matters with practitioners. Although data is not available for the clients of social work settings, Read, King, & Watson’s (1997) survey, which focuses in on the prevalence of sexual dysfunction within primary care settings, suggests that although there is a high prevalence of sexual

problems among patients, patients rarely disclose those problems with their general practitioner. Sexuality that exists outside of The Diagnostic and Statistical Manual of Mental Disorders may be a largely neglected topic in private practice although there is little research that addresses this question (Bhugra, Popelyuk & McMullen, 2010).

The majority of practitioners understand that sexuality is an important part of an individual's mental health and believe that it is part of the practitioner's job to address it (Weerakoon, Jones, Pynor, & Kilburn-Watt, 2003). Yet, honest dialogue regarding sexuality remains taboo (Eaklor, 2008). Discussions regarding sexuality do not occur within schools (Guttmacher, 2014), or in medical or mental health settings (Read, King, Watson, 1997; Rele & Wyle, 2007). If open discussion on topics concerning sexuality are absent in so many contexts, how can our society foster sexual health, let alone prevent and resolve social problems involving sexuality? It is for this reason that research on the topic of sexuality in individual practice by LCSWs is a required step in the field of social work.

## Chapter 3

### **Methodology**

This chapter will discuss the study designed used, sampling procedures, the data collection process, the instrumentation, data analysis, and the measures taken to protect participant confidentiality.

### **Study Design**

There is a scarcity of scholarly research concerning how clinicians address sexual topics in individual therapeutic contexts. This project attempts to fill a gap in the literature by providing insight to questions such as the following: Is sexuality addressed if the client does not introduce the topic? What is the general level of comfort and scope of knowledge regarding sexual topics among licensed clinicians? How do social work clinicians compare to other professional mental health professionals in terms of sex positivity?

According to Toseland (2011), an exploratory research design is utilized when there are very few studies available to refer upon. For this reason it is appropriate to conduct an exploratory mixed-methods study. A disadvantage to using this type of design is that qualitative research utilizes smaller sample sizes resulting in findings that cannot be generalized to the larger population. Additionally, the exploratory nature impedes the researcher's ability to make definitive conclusions regarding the findings. It is in the hopes of the researchers that the findings of this project will provide insights that can be expanded upon in later investigation.

### **Data Collection Procedures**

This research project utilized the Internet based survey tool Survey Monkey to conduct an online survey. The researchers had a limited ability to reach a broader, more randomized sample, so the convenience sample method was most appropriate for the purposes of this survey. Clinicians who were known to provide individual therapy were identified and invited to participate in the study. Participation was solicited via electronic mail and included a statement detailing the purpose of the study and the corresponding link to access the survey. Respondents were then encouraged to invite colleagues whom they felt would be interested in participating. Additionally, the researchers utilized social media by posting the recruitment email and corresponding online survey on professional pages directed towards clinicians.

A letter of consent was built into the data collection tool. In order to submit the survey, participants were required to have provided their consent. To preserve the confidentiality of those responding to the survey, no personal information or IP addresses were collected during the research process. The survey was available from December 8, 2014 through February 28, 2015.

### **Participants**

The population sampled for this project was masters level and above clinicians who provide individual therapy in the various fields of mental health. The sample consisted of 75 clinicians between the ages of 25-75. Both the average (mean) and the median age of the sample was 46. Of the participants, 80% practiced in the field of social work while 15% practiced in other mental health fields. Regarding gender, 81%

identified as female and 19% identified as male.

### **Instrumentation**

The questionnaire is comprised of twenty-five questions that can be divided into three subtopics: (I) demographics, (II) practice description, and (III) addressing sexuality in practice. All but the last two questions were primarily quantitative with some opportunities for participants to comment on their quantitative responses. In part I, researchers collected demographic information on the participants' area of practice, gender, sexual orientation, age, and race/ethnicity. In part II, the questionnaire captures the contexts of the therapeutic services by asking questions about the clinicians' employment settings and the populations they serve.

Part III considers a range of reasons for receiving services from specific diagnostic categories to more general areas of concern. It also explores the factors considered when addressing sexuality, theoretical orientations and models used to inform the clinician's approach to addressing sexuality, the clinician's comfort level in addressing sexuality, and knowledge level with regards to various sexual topics. Additionally, there are questions that elicit responses regarding the professional and personal influences that inform the clinician's approach to sexuality. The survey concludes with two qualitative questions that provide respondents with an opportunity to share information they think is important when considering sexuality in the context of individual practice.

### **Instrumentation Within the Questionnaire**

Within the questionnaire three sub scales were developed that focus on different

aspects of sex positivity in practice.

**Sexuality in Practice: Self-Reported Knowledge Scale.** The Self-Reported Knowledge Scale is designed to measure a practitioner's level of knowledge regarding sexuality. The scale is made up of a single question that asks participants to rate their knowledge of twelve sexuality related topics. The topics were selected to represent a range of concepts including sexual orientations (e.g. "heterosexuality", "bisexuality", "homosexuality", "asexuality", "pansexuality"), aspects of the sexual experience ("sexual safety" and "pleasure"), relationship constructs (e.g. "monogamy", "polyamory"), forms of sexual expression (e.g. "alternative forms of sexual expression (fetishes)"), and other areas of difficulty (e.g. "issues of intimacy", "issues with body image"). Inclusion is at the core of sex positive feminism which is reflected in the in the construction of this scale (Goodwach, 2005).

The response to each topic is in a 0 to 4 Likert Scale format. With this coding a score of 0 indicates very low self-reported knowledge of sexuality, in contrast to the highest possible score of 48 which indicates self-reported expertise or specialization in sexuality.

**Sexuality in Practice: Practitioner Comfort.** The Practitioner Comfort Scale is designed to assess how comfortable a practitioner feels addressing sexuality overall in practice as well as specific aspects of sexuality. The measurement has two equally weighted parts and is made up of data collected from two different questions. Part I uses assesses overall practitioner comfort addressing sexuality. Part II assesses practitioner comfort addressing specific topics. The topics included in this scale are the same ones



used in the Self-Reported Knowledge Scale.

Overall comfort in Part I is weighted to be equal to specific comfort levels in Part II because of the importance of cultural humility, open mindedness and inclusion of the unknown. A practitioner's comfort discussing sexuality in general better prepares them to discuss any unfamiliar topic a client may bring up as well as a willingness to learn from the client about their unique understanding of their sexuality. All the responses, in both parts, are in a 1 to 5 Likert Scale format. With this coding and the weighted sections the lowest possible score of 24 indicates a practitioner is very uncomfortable where as a high score of 120 indicates a practitioner is very comfortable addressing sexuality in practice.

**Sexuality in Practice: Perception of Importance.** The Perception of Importance Scale is designed to assess how important a practitioner thinks addressing sexuality with a client is. The measurement is made up of two equally weighted parts. Part I and Part II are both based on one question set that asks, "How important is addressing sexuality with the following client groups?" The client groups were labeled based on the diagnostic categories described in fifth edition of The Diagnostic and Statistical Manual of Mental Disorders. The categories are, "Adjustment Disorders", "Anxiety Disorders", "Depressive Disorders", "Neuro-Psychological Disorders (ADHD, Asperger's, Autism)", "Personality Disorders", "Psychotic Disorders", "Grief and Loss", "Interpersonal/Relationship Concerns" and "Sexual Dysfunction Disorders."

In response participants indicate their perception of importance using a 1 to 5 Likert Scale format. Part I includes all the responses to the diagnostic categories, except for "Sexual Dysfunction Disorders," which is the only diagnostic category in Part II. The

parts were coded in this manner because of the blatant importance of addressing sexuality with clients who are experiencing clinically significant diagnosable sexual dysfunction. While the other diagnostic categories do not directly demand assessment of a client's sexual expression discussing sexuality with a client who is diagnosed with sexual dysfunction would leave their clinically significant symptoms unaddressed.

With the scores from Part I and Part II participants could earn the lowest possible score of 16 indicating their perception of addressing sexuality as very unimportant, all the way up to a high score of 80 which indicates their perception of addressing sexuality is very important.

### **Data Analysis**

The quantitative data gathered using the online questionnaire was then converted automatically into a format compatible with the program Statistical Package for Social Sciences (SPSS). Researchers then reviewed the data to correct any errors caused by compatibility and formatting issues between the two programs. The majority of the quantitative data was coded into string (nominal) and ordinal (scale) variables. Questions such as age, which asked participants to fill in a number was then reorganized into ranges and coded as ordinal (scale) variables. The qualitative data collected was not analyzed using SPSS and was ultimately discarded because of the inadequacy of the sample size. Using SPSS the quantitative data was analyzed using descriptive statistics, producing absolute frequency distributions, grouped frequency distributions and percentage frequency distributions.

Data used in the three scales was coded into SPSS. Each participant that

completed the questions associated with the scale was then scored on each of the individual scales. Participant's scores were then divided into two categories, Social Work and Other, based on participant's licensure type or educational background. A mean for each scale for each group was then established and compared using an independent sample t-test.

### **Protection of Human Subjects**

This project's application for the Protection of Human Subjects was prepared and submitted for the review and approval of the Division of Social Work Human Subjects Review Committee in the fall of 2014. Approval was granted at the Minimal Risk level on December 12, 2014.

## Chapter 4

**Analysis****Demographics**

This study is made up of quantitative data collected from 75 questionnaires that were completed by a sample group of 75 mental health care professionals who provide individual therapy. The demographic makeup of the sample is described as follows:

Table 1

*Participant Age*

Ages	Freq.	%
25-35	22	2.93%
36-45	12	16%
46-55	17	22.6%
56-65	12	16%
65-above	9	12%
Decline to state	3	4%
Total	75	99.9%

Due to the wide range of ages reported, the data has been compressed into the ranges in the table above.

The sample size of the study was 75 participants, ranging from ages 25-87. The average age of all participants was 46. Twenty-two percent of participants surveyed were between the ages of 25-35, while individuals between 36-45 years of age comprised twelve percent of the sample. Participants ages 46-55 constituted seventeen percent of the sample. Ages 56-65 represent twelve percent of the sample. A mere nine percent of

the sample were ages 65 and above. Lastly, of the 75 participants three respondents declined to report their age. The mean age of the sample was 44.79, while the median age was 46. Lastly, the mode age was 25.

Table 2

*Participant Area of Practice*

Area of Practice	Freq.	%
Social Work	60	80%
Marriage and Family Therapy	13	17.3%
Psychology	2	2.7%
Total	75	100%

The survey offered the participants 12 options for area of practice and clinical licensure: masters of social work (MSW), associates of social work (ASW), licensed clinical social worker (LCSW), social work Ph.D, marriage and family therapist intern (MFTI), licensed marriage and family therapist (LMFT), psychologist PH.D or intern, professional counseling intern, limited license professional counselor (LPCC), limited license professional counselor (LPCC), medical doctor (Psychiatrist), and American Society of Sex Educators, Counselors and Therapists (ASSECT), and other. Of the twelve options, participants only identified as MSWs, ASWs, LCSWs, social work Ph.Ds., MFTIs, LMFTs and psychologist Ph.Ds. or interns. For the purposes of this project, the table provided above combines area of practice into three categories: social worker, marriage and family therapy, and psychology.

The majority of the sample, 80%, was comprised of participants who identified

their area of practice to be social work. Marriage and family therapists constituted 17.3% of the sample. A mere 2.7% of the sample was comprised of participants who identified their area of practice to be psychology.

Table 3

*Participant Gender*

Gender	Freq.	%
Female	61	81.3%
Male	14	18.7%
Total	75	100%

Participants were able to select three options for gender identity: female, male, and transgender. Of the choices provided, all participants in the study identified as either female or male. Female participants constituted 81.3% of participants, while males comprised 18.7% of participants.

Table 4

*Participant Sexual Orientation*

Sexual Orientation	Freq.	%
Heterosexual	55	73.3%
Bisexual	7	9.3%
Homosexual	7	9.3%
Asexual	1	1.3%
Pansexual	4	5.3%
Prefer Not to Answer	1	1.3%
Total	75	100%

The sexual orientation portion of the questionnaire was broken down into seven identifiers: heterosexual, bisexual, homosexual, asexual, pansexual, pomosexual, and “prefer not to answer”. Of the given choices, all identifiers were selected by participants except for pomosexual. Participants who identified as heterosexual constituted the majority of the population and represented 73.3% of the sample. Bisexual and homosexual as a self-identifier were equally represented as 9.3%. Participants who identified as asexual comprised 1.3% of the sample, while 5.3% identified as pansexual. Participants who selected prefer not to answer represented 1.3% of the sample.

Table 5

*Participant Race/Ethnicity*

Ethnicity	Freq.	%
American Indian or Alaskan Native	2	2.7%
Asian or Pacific Islander	2	2.7%
Black or African American	1	1.3%
Hispanic American	6	8.0%
White/Caucasian	58	77.3%
Other/Unreported	6	8.0%
Total	75	100%

In Race/Ethnicity portion of the questionnaire, participants were offered six identifiers: American Indian or Alaskan Native, Asian or Pacific Islander, Black or African American, Hispanic American, White/Caucasian, and other/unreported. Both American Indian or Alaska Native and Asian or Pacific Islander represented 2.7% of the survey. A mere 1.3% of participants reported to be Black or African American. Hispanic American comprised 8% of the sample, while White/Caucasian constituted the majority of the sample at 77.3%. The final 8% of the sample was comprised of participants who choose other/unreported.

### **Overall Findings**

The purpose of this survey is to assess if and how clinicians address sexuality in individual therapy. The data collected regarding this question was analyzed and organized into the following categories:



### **Initiation of Sexuality Discussion**

The researchers aimed to capture data that would reflect when in the therapeutic relationship that discussions regarding sexuality occur. The researchers assessed this by asking clinicians the following question: “When are you most likely to address sexuality with your clients?” In developing this question, the researchers considered that a clinician’s approach might change depending on the client’s needs. For example, a clinician may be more likely to bring up sexuality sooner in a therapeutic relationship when the client presents with a sexual dysfunction disorder than with a client who presents with a psychotic disorder. For this reason, participants were asked this question in reference to several diagnostic categories and/or presenting reasons. In response, participants were allowed to select one of the following fixed answers “by the 3rd session”, “at some point after the 3rd session”, “I will only discuss sexuality if my clients request to” and “I never discuss sexuality with my clients who present with this.” Of the 75 participants who completed the questionnaire 58 answered this series of questions.

The researchers interpreted the data collected as indicative of the participant’s perspective on whether it is the clinician or client’s role to initiate discussions surrounding sexuality. The first three responses, “during the 1st session”, “by the 3rd session”, “at some point after the 3rd session” implies that the clinician would initiate the discussion. The response “I will only discuss sexuality if my clients request to” indicates that the clinician would wait for the client to initiate the discussion. The last response, “I will never discuss sexuality with my clients who present this,” needs no

interpretation. The chart that follows presents this interpretation of the data:

Table 6

*Initiator of Sexuality Discussion*

Diagnosis/ Presenting Reason	Clinician Initiates		Client Initiates		Never	
	Freq.	%	Freq.	%	Freq.	%
Adjustment Disorders	34	45%	24	32%	0	0%
Anxiety Disorders	38	50.7%	20	26.7%	0	0%
Depressive Disorders	40	53.3%	18	24%	0	0%
Neuro-Psychological Disorders	27	36%	27	36%	0	0%
Personality Disorders	36	48%	19	25.3%	0	0%
Psychotic Disorders	27	36%	26	34.7%	2	2.7%
Grief and Loss	34	36%	22	29.3%	1	1.3%
Interpersonal/Relationship Concerns	48	64.0%	10	13.3%	0	0
Sexual Dysfunction Disorders	47	62.7%	10	13.3%	0	0

The chart provided illustrates that more than half of participants indicate that it is the clinician's role to initiate discussion regarding sexuality when the client is seeking services for anxiety disorders, depressive disorders, interpersonal personal/relationship concerns and sexual dysfunction disorders. In general, the chart shows a much higher frequency of responses that indicate that discussion is the clinician's role and a lower frequency of responses that indicate discussion is the client's role. An exception to the preceding statement is participants' responses regarding neuropsychological disorders and psychotic disorders in which clinician initiates and client initiates is equally represented.

## Therapeutic Frameworks & Models

As mentioned in prior chapters, the researchers were interested in exploring which therapeutic frameworks and models are utilized by clinicians to address sexuality.

Chapter 2 provides summaries of various framework/models that are used by clinicians to inform and guide their approach. The researchers asked participants “When addressing sexuality in therapy which of the following do you use: behavioral techniques, narrative techniques, eclectic techniques (e.g. bio-psycho-social model), and the PLISSIT model (permission, limited information, specific suggestions, and limited therapy)?” The researchers acknowledged that the list of theoretical frameworks/models provided was not exhaustive. Thus, the researchers provided an opportunity for participants to write a narrative about the other techniques or models used to address sexuality in therapy.

Unfortunately, not enough participants responded for the qualitative data to be reported.

Of the 75 respondents, 55 provided responses.

The following table breaks down participant responses by each therapeutic technique.

Table 7

### *Therapeutic Techniques*

Model/Technique	Use		Do not use	
	Freq.	%	Freq.	%
Behavioral	25	33.3%	30	40%
Narrative	24	32%	31	41.3%
Eclectic	46	61.3%	9	12%
PLISSIT	6	8%	49	65.3%

Of the therapeutic models/frameworks provided, eclectic techniques appear to be utilized the most, with 61.3% of participants reporting its use. A little over 30% of participants reported using behavioral techniques and narrative techniques. A mere 8% reported using the PLISSIT model. This is notable, as the PLISSIT model is the only model of the options provided that was developed to assist clinicians in conceptualizing client's concerns with regards to sexuality (Dunk, 2007). Perhaps this is because the model was developed for the use of healthcare professionals; its usefulness to guide mental health clinicians' therapeutic approach has only been recognized in the past 10 years (Dunk, 2007; Timm 2009).

### **Influencing Factors**

The researchers realized that there are many professional and sociocultural factors that could potentially impact clinicians' approach to sexuality. Thus, the researchers attempted to assess the degree that various factors influence the participants by asking participants "To what degree do the following inform/influence how you address sexuality with your clients: graduate education, continuing education, religious beliefs, cultural beliefs, and personal discomfort?" Of the 75 participants, 57 answered this series of questions.

Table 8

*Influencing Factors*

Factors	Low		Medium		High		No Influence	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Graduate Education	7	9.3%	21	28%	21	28%	8	10.7%
Continuing Education	5	6.7%	16	21.3%	31	41.3%	4	5.3%
Religious Beliefs	22	29.3%	13	17.3%	12	16%	11	14.7%
Cultural Beliefs	11	14.7%	24	32%	20	26.7%	3	4%
Personal Discomfort	25	33.3%	16	21.3%	4	5.3%	12	16.0%

Of the influencing factors presented in the chart above, continuing education appears to have the most participants, 41.3%, reporting that it has a high degree of influence on how they address sexuality with their clients. In contrast, only 28% of participants report that graduate education has a high degree of influence.

Religious beliefs and personal discomfort were reported to have the lowest degree of influence. Thirty three point three percent of participants self-reported that personal discomfort has a low degree of influence, while 29.3% of participants reported that religious beliefs have a low degree of influence. However, it must be considered that self-report relies on the honesty of its participants and their introspective ability (Hoskin, 2012).

### **Sex Positive Considerations in Practice**

Sex positive considerations in practice are assessed using the data collected from question 20. The seven part question asks: “When addressing sexuality with a client what

factors do you consider? (Check all that apply).” The seven factors are: Sexual Orientation (e.g. Heterosexual, Bisexual...), Relationship Orientation (e.g. Monogamous, Polyamorous), Sexual Safety, Pleasure, Issues of Intimacy, Body Image, and Alternative Forms of Sexual Expression (Fetishes). Of the 75 participants who completed the questionnaire 57 answered this series of questions. The chart below shows the frequency of indications for each factor. It is notable that 96.49% of participants indicated that they do consider sexual orientation, which was the most commonly considered. In contrast the two least frequently considered categories were pleasure (71.93%) and alternative forms of sexuality (45.61%).

Table 9

*Sex Positive Considerations In Clinical Practice*

Sex Positive Considerations	Responses	
	Freq.	%
Sexual Orientation	55	96.49%
Relationship Orientation	53	92.98%
Sexual Safety	52	91.23%
Body Image	49	85.96%
Issues of Intimacy	49	85.96%
Pleasure	41	71.93%
Alternative Forms of Sexual Expression	26	45.61%

**Sexuality in Practice Scales**

Within the survey three scales that measure different aspects of sexuality in

practice were developed. The three areas are knowledge, comfort and perceived importance of sexuality in the context of practice. The sample size and information about the scores on each of the three of these scales is represented in the chart below.

Table 10

*Reference Chart: Sexuality in Practice Scales*

SIPS	Area of Practice	N	Mean	Std. Deviation	Std. Error Mean
Knowledge	Social Work	46	28.4565	5.68314	.83793
	Other	12	31.1667	4.64823	1.34183
Comfort	Social Work	45	94.5556	17.92986	2.67283
	Other	11	107.2727	15.86878	4.78462
Importance	Social Work	44	66.1136	8.74501	1.31836
	Other	11	64.5455	14.27840	4.30510

Table 11

*Reference Chart: Comparison of Clinician's Sex Positivity Using SIPS*

		Independent Samples Test								
		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
Knowledge	Equal variances assumed	.466	.498	1.521	56	.134	2.71014	1.78128	-.85819	6.27848
	Equal variances not assumed			1.713	20.490	.102	2.71014	1.58197	-.58474	6.00503
Comfort	Equal variances assumed	.582	.449	2.152	54	.036	12.71717	5.90847	.87140	24.56294
	Equal variances not assumed			2.320	16.842	.033	12.71717	5.48056	1.14595	24.28839
Importance	Equal variances assumed	2.635	.110	-.464	53	.645	-1.56818	3.37963	-8.34685	5.21049
	Equal variances not assumed			-.348	11.939	.734	-1.56818	4.50244	-11.38371	8.24734

**Sexuality in Practice Scale: Self-Reported Knowledge**

This measurement uses the data collected from question 23 to evaluate a practitioner's self-reported knowledge of topics related to sexuality. Of the 75 participants total, 46 social workers and 12 practitioners from other fields completed this portion of the questionnaire. The range of possible scores for this scale is 0 to 48. A score of 0 indicates that a participant reported having no knowledge of any of the twelve concepts. In contrast a score of 48 indicates that a participant reports high knowledge in all twelve of the concepts.



The sample of social work participant's scores ranged from 17 to 44 compared to the other group scores which ranged from 23 to 41. An independent t-test was conducted to compare the Non Social Work group scores to the Social Work group scores. There was not a statistically significant difference between the Non Social Work group (M=31.17, SD=4.65) and Social Work Group (M=28.46, SD=5.68) scores for the scale;  $t(56)=1.52$ ,  $p=0.13$ . Equal variance within the sample was confirmed using Levene's Test for Equality of Variance ( $F=0.466$ ,  $Sig=0.498$ ).

### **Sexuality in Practice Scale: Practitioner Comfort**

This measurement is designed to assess a practitioner's comfort level addressing sexuality in practice. Of the 75 participants total, 45 social workers and 11 practitioners from other fields completed this portion of the questionnaire. The possible score range for this scale is 24 to 120. A score of 24 indicates that a participant reported feeling "Very Uncomfortable" addressing sexuality in practice both in general and regarding the twelve specific sexuality concepts. In contrast a score of 120 indicates that a participant is "Very Comfortable" addressing sexuality in practice in general and regarding the twelve specific sexuality concepts.

The social work group's scores ranged from 49 to 120 compared to the non social work group's scores, which ranged from 67 to 120. An independent t-test was conducted to compare the non social work group scores to the social work group scores. There was a statistically significant difference between the Non Social Work group (M=107.27, SD=15.87) and social work group (M=94.56, SD=17.93) scores for the scale;  $t(54)=2.15$ ,  $p=0.036$ . Equal variance within the sample was confirmed using Levene's Test for Equality

of Variance ( $F=.582$ ,  $Sig=0.449$ ). Based on the data analysis an important difference can be observed between the two groups. Mental health care professionals who have a background in social work are less comfortable discussing sexuality overall and specific topics related to sexuality than mental health care professionals from other fields.

### **Sexuality in Practice Scale: Perception of Importance**

This scale is designed to measure how important a practitioner thinks sexuality is in practice. Of the 75 participants total 11 Non Social Workers and 44 Social Workers completed this portion of the questionnaire.

For this scale there is a possible score of 16 to 80. A score of 16 indicates that a participant reported that addressing sexuality is “Very Unimportant” in practice with clients in all nine of the diagnostic categories. In contrast a score of 80 indicates that a participant reported that addressing sexuality is “Very Important” in practice with clients in all nine of the diagnostic categories.

The social work group’s scores ranged from 48 to 80 while the non social work group’s scores ranged from 30 to 80. An independent t-test was conducted to compare the non social work group scores to the social work group scores. There was not a statistically significant difference between the non social work group ( $M=64.55$ ,  $SD=14.28$ ) and social work group ( $M=66.11$ ,  $SD=8.75$ ) scores for the scale;  $t(53)=-0.46$ ,  $p=0.65$ . Equal variance within the sample was confirmed using Levene’s Test for Equality of Variance ( $F=2.635$ ,  $Sig=0.11$ ).

### **Summary of Significant Findings**

The Sexuality in Practice Scales (SIPS) are designed to take a basic measure three areas of sex positivity within an individual practitioner. Due to the number of differing variables within sample and differences in sample size between the social work group and the group from other fields within this study it is not possible to infer anything about the population over all. In comparing the two group there was no significant difference in either the SIPS: Self Reported Knowledge scores or the SIPS: Perception of Importance scores.

A comparison of the two groups using the SIPS: Practitioner Comfort did show a statistically significant difference. This suggests that mental health care professionals from the field of social work are less comfortable discussing sex than their peers from other backgrounds such as marriage and family therapy and psychology. This significant finding about comfort highlights the need for more research on the affect of comfort level on practice. In addition, more research about the other factors that may influence a practitioner's comfort level is needed. The difference in comfort level is made more meaningful when the context of the lack of difference in the other two scales is considered.

## Chapter 5

### **Discussion**

Sexuality is an aspect of every individual that must not only be ignored but embraced and respected. Each individual client in micro therapeutic work, community in meso work and population in macro work is affected in some way or another by the handling of sexual expression. In the field of social work at each of these levels sexuality must be considered in order to practice the most culturally competent effective work.

#### **Initiation of Discussion on Sexuality in Practice**

One aspect of this research study specifically examined if a discussion of sexuality occurs in clinical practice. This included when sexuality was discussed and who broached the subject first. In clinical practice with clients presenting with Anxiety Disorders, Depressive Disorders, Interpersonal/Relationship Concerns, and Sexual Dysfunction Disorders, frequencies indicate that more than half of the participants in the sample thought it was the clinician's role to initiate a discussion about sexuality.

Often the objective of clinical practice in the mental health care setting is to decrease negative symptoms, reduce distress and lessen the negative aspects of a client's life. In addressing sexuality a mental health care practitioner has the opportunity to impact an aspect of their client's life that has tremendous potential to either improve diminish quality of life. Shame, discomfort, lack of knowledge and perception of importance are all factors that may contribute to the neglect of such a potentially important topic by both the clinician and the client. The reasons a clinician chooses not to address sexuality or relies on the client to initiate the discussion must be carefully

explored and based on clinical reasoning opposed to a clinician's internal biases.

### **Theoretical Models & Frameworks**

Based on the findings from this study the majority of participants reported using eclectic techniques as their therapeutic model when addressing sexuality in clinical practice. Eclectic techniques were described on the questionnaire as including the biopsychosocial approach, strengths based approach and The Recovery Model. These three eclectic techniques all align with the empowering and holistic values of the social work and mental health care professions so it follows that they are most commonly implemented.

Narrative and behavioral techniques were each reported as being used about half as often as eclectic techniques by participants. These approaches are currently popular in addressing many other issues and have led to the development of many evidence-based techniques including cognitive behavioral therapy, Dialectical Behavior Therapy and Acceptance and Commitment Therapy. It is notable that behavioral techniques were indicated by only a third of the sample because of their role as the origin of sex therapy (Fischer & Gochros, 1977). Operant conditioning, exposure therapy and manipulation of behavior with positive and negative reinforcement are all techniques that date back to the beginning of sex therapy and the research of Masters and Johnson (Fischer & Gochros, 1977). These techniques have also been criticized for their focus on reduction and treatment of behavior that is marginalized and labeled as deviant (Bhugra, Popelyuk & McMullen, 2010). As the third most commonly used technique behavioral therapy is clearly still a mainstay of the treatment of sexuality in practice but it is no longer used by

a definitive majority.

The PLISSIT Model (Permission, Limited Information, Specific Suggestions and Intensive Therapy) was by far the least popular model reported with only 8% of participants indicating they use it in clinical practice when addressing sexuality with a client. This model was the only option that was specifically developed to address a client's concerns with regards to sexuality and sexual well-being. Specialize techniques, by their very nature are not applicable to all areas of practice, but they are valuable tools when addressing especially sensitive or controversial topics. Suicidal ideation, homicidal ideation, child abuse, elder abuse and self-harm are all potentially difficult topics to discuss and are therefore often addressed using specific techniques that require specialized clinical training. Similarly, it may be required that clinicians use specialized techniques and receive additional training before they can skillfully address sexuality in clinical practice.

### **Influencing Factors**

In an attempt to not only understand how and if sexuality is addressed the researchers included a section in the questionnaire that explores what professional and personal factors may contribute or shape the way a clinician approaches sexuality in clinical practice. Due to the limited scope of this research study it is not possible to report on all the data that this portion of the questionnaire yielded. In the context of this study and in regards to implications for future research it can be noted that 28% of participants reported that their graduate education had a high degree of influence whereas, 41.3% reported that continuing education had a high degree of influence on their treatment of

sexuality with a client. Although these findings are not conclusive, this may indicate that the participants' approach to sexuality may be informed more by continuing education than graduate education.

### **Sex Positive Considerations**

When a mental health care practitioner completes a client assessment, develops a treatment plan, makes referrals and identifies treatment goals there are a multitude of factors to consider. The complexity of a single client's life cannot be fully addressed in clinical practice (Engel, 1980). Regardless as a part a biopsychosocial assessment it is expected that biological, psychological and social factors are each considered within a client's multilevel system (Engel, 1980). However inclusive, a framework of sexuality is often not explicitly listed as a factor that should be addressed and is therefore excluded from assessment and treatment that closely follows the guidelines (Rossi, 1994).

A clinician who understands the potential impact of a client's sexuality on their mental health considers sexual orientation, relationship orientation, sexual safety, sexual expression as well as aspects that may impact sexuality such as intimacy, body image and physical pleasure as a part of their practice. As a part of this study the researchers asked participants what aspects of sexuality they consider in clinical practice. A client's sexual orientation was the most frequently considered factor by 96.49% of the participants.

Sexual pleasure and alternative forms of sexual expression such as fetishes were the least frequently considered. Pervasive sex negativity as well as a lack of basic knowledge about non-normative forms of sexual expression may contribute to these factors frequently being overlooked or even deliberately avoided.

### **Summary of Sexuality in Practice Scales**

With this exploratory study the researchers endeavored to develop a preliminary map of how and if sexuality is addressed in clinical practice. With the quantitative data collected from the 75 online questionnaire responses several areas of note were distinguished. The sample was comprised mostly of social workers. However, the sample also included a small number of clinicians from other areas of practice. Thus, the resulting findings regarding sexuality and the initiation of discussions, the models used, and influencing professional and personal factors reflect this diverse group of practitioners. Using this diverse sample resulted in an opportunity to use scales to make interesting comparisons between social work clinicians and clinicians from other areas of practice.

The three Sexuality in Practice Scales (SIPS) were intended to assess for different factors influence how a mental health care professional address sexuality. An individual's knowledge, comfort, and perception of importance are multifaceted and complex making them difficult to quantitatively measure. These scales are intended to be basic indicators, not tools for general inference of thorough assessment. Due to their simplistic nature they may be valuable for large quantitative research within an agency, university or organization.

With the SIPS: Self-Reported Knowledge, the researchers compared the knowledge level of social work clinicians with that of non-social work clinicians regarding various sexuality related concepts including different sexual orientations, sexuality safety, pleasure, various relationship constructs (i.e. polyamory), other forms of



sexual expression (i.e. fetishes), and additional areas of sexual difficulty (i.e. issues with intimacy). Findings show that there was not a statistically significant difference between the non-social work group and the social work group. Thus, the research indicates that there is no difference between the self-reported knowledge level of mental health practitioners who have a background in social work and practitioners from other areas of practice.

The SIPS: Perception of Importance, aimed to assess participants' beliefs regarding the importance of discussions pertaining to sexuality. In consideration of the many client driven factors that may impact a clinician's perception of importance the researchers considered importance with reference to the nine diagnostic categories/presenting reasons, outlined in the chapters prior (i.e. depressive disorders and interpersonal/relationship concerns). The findings show that there is no difference between the two groups in the perceived level of importance of discussions regarding sexuality.

A statistically significant difference was found when measuring practitioner comfort level with addressing sexuality in practice;  $t(54)=2.15$ ,  $p=0.036$ . The SIPS: Practitioner Comfort included an assessment of the participants' overall level of comfort with discussing the topic of sexuality in general. The scale was also assessed clinicians level of comfort with reference to more specific aspects of sexuality, as it took into account the same sexuality related concepts considered in the SIPS: Self-Reported Knowledge. The analysis of the data shows a statistically significant difference between the scores of social work clinicians and clinicians from other areas of practice such as

marriage and family therapists and psychologists. The findings suggest that social work clinicians are less comfortable with discussing sexuality than non-social work clinicians.

A practitioner's level of comfort of sexual issues may have an influence on their willingness to have discussions regarding sexuality with their client (Timm, 2009). Sex negativity has historically impacted the treatment of sexual issues on a micro, meso, and macro level (Goodwach, 2005). The result of this sex negativity is the minimization of sexual health and pleasure. It has also resulted in sociosexual issues such as sexual violence and sexual dysfunction to receive more attention.

The National Association of Social Workers (NASW) Code of Ethics (2008) promotes an approach to sexuality that is positive and respectful. The results of the SIPS: Practitioner Comfort suggests that in the sample used for the study, social work clinicians are less sex positive than clinicians from other fields of mental health. Could this finding imply some truth in Jeyasinghams (2008) claim that sex negativity and practitioner discomfort is perpetuated by the discipline of social work itself? Further research is needed to assess the impact of comfort level on practice.

### **Limitations & Implications For Future Research**

The sampling method utilized for the purposes of this study was based on convenience. There were also significant differences in the sample size between social work and non-social work clinicians. Thus, it is not possible to infer anything about the larger population of mental health practitioners who provide individual therapy. Future research should include a larger more randomized sample of participants for a better representation of the general population of clinicians.

With reference to the three SIPS, there are a number of different variables that could influence the areas that the researchers attempted to assess. For example, the years a clinician is in practice may impact knowledge, comfort, and perception of importance? Further, a social work practitioner who provides therapy in an non-profit agency that serves clients who are formerly homeless and require a high level of care may perceive sexuality as less important than a marriage and family therapist providing therapy in private practice. Future research should consider these variables and attempt to control for them when comparing one group of clinicians to another.

This consideration of practice setting leads another recommendation for future research; to what degree are areas like comfort and knowledge are influenced by the clinician's practice setting? SIPS could be used to make comparisons between clinicians from different practice settings, rather than clinicians from different areas of practices. Perhaps the preliminary statistically significant difference found between the social work group and the non-social works group level of comfort have more to do with agency setting and less to do with their educational background.

This study is primarily based on quantitative data, which can be problematic when attempting to fully understand a multi-dimensional topic such as sexuality. The questionnaire required participants to select responses to questions that might have been better answered by narrative responses. Based on the qualitative feedback to the questionnaire some participants may have found the wording ambiguous. Narrative responses and the corresponding qualitative data result in more in depth responses and clearer insight on how clinicians address sexuality. Further, a client's experiences cannot

be reduced to diagnosis and/or single presenting concerns. Narrative responses would have provided opportunities to provide context and elaborate on the reasons why participant's approach to sexuality changes from one client to the next.

Another limitation is very little research exists on how to quantitatively assess how clinician's address sexuality in individual therapy. Thus, the instrument has not been tested for validity.

### **Implications for Social Work**

Due to the limited amount of research on sexuality in practice by social workers this study was intended to broadly explore general factors and influences. The findings, however limited, highlight the importance of research in this field. Assessment, discussion and treatment of sexual dysfunctions and difficulties as well as the promotion of sexual health are all important issues to practice that by and large are under studied. Further, how sexuality is taught in social work programs, reinforced by licensing requirements and perceived by professionals in the field are all unmeasured factors that shape this aspect of practice. More research on the impact of work setting, a practitioner's access to continuing education classes and personal factors may inform how the profession can grow and improve.

According to the National Association of Social Workers (NASW) Code of Ethics (2008), social workers should strive to understand the nature of diversity and oppression with respect to sex, sexual orientation, gender identity, and expression. This principle can only be fully realized if more comprehensive research regarding sexuality occurs.

## **Conclusion**

More qualitative and quantitative exploratory research on the topics covered in this study are necessary. In addition, specific topics require more specialized research such as the impact of trauma on the handling of sexuality in therapy. Systemic issues related to sexuality must be reviewed at the same pace that our society changes, especially because of the impactful and taboo nature of the subject. Researching the changing relationship between the field of sex therapy and general therapy as well as the experience of the population will be important to understanding micro, meso and macro level role mental health care providers must play.

There is no aspect of human sexuality that is fully understood. Due to the dynamic nature of society and the human experience it will never be fully understood. Research that goes beyond the exploratory level is required to discern how this aspect of the human experience can be better supported by the profession of social work. Understanding is a powerful first step, but only the beginning of a crucial march toward progress.

## Appendix A

### Consent to Participate Form

#### Welcome: Request For Participation

**This study assesses the degree to which sexuality is addressed in individual therapy. This survey is conducted as part of the master's thesis project of Miriam Yelton and Natalie Delfin at California State University, Sacramento.**

**Under no circumstances will your contact information be shared with any individual other than the two principal investigators and Teiahsha Bankhead, Ph.D, bankhead@csus.edu.**

Your participation in this study is completely voluntary and you may choose not participate at anytime. This survey will be confidential and anonymous, in that none of your identifying information including your IP address or email address will be recorded. Thank you for your participation and consideration!

If you have any questions regarding this study feel free to contact the principal investigators:

Miriam Yelton, MSW and Natalie Delfin, MSW  
yelton.delfin.thesis@gmail.com

#### 1. Consent to Participate:

I consent to participate in this study.

Comments

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#### Demographic Information

## Appendix B

### Questionnaire

\* 2. What is your clinical license or associates area of practice?

- |  |   |
|--|---|
| <input type="checkbox"/> MSW               | <input type="checkbox"/> Psychologist, Ph.D or Intern   |
| <input type="checkbox"/> ASW               | <input type="checkbox"/> Professional Counseling Intern |
| <input type="checkbox"/> LCSW              | <input type="checkbox"/> LPCC                           |
| <input type="checkbox"/> Social Work, Ph.D | <input type="checkbox"/> MD (Psychiatrist)              |
| <input type="checkbox"/> MFTI              | <input type="checkbox"/> AASECT Certified               |
| <input type="checkbox"/> LMFT              |   |
| <input type="checkbox"/> Other:            |   |

3. What is your gender?

- Female
- Male
- Transgender
- Other

\* 4. How would you describe your sexual orientation? (Please provide any other information about your sexual orientation, expression or identity that you feel comfortable sharing in the comment box below).

- |                                       |   |
|---------------------------------------|---|
| <input type="checkbox"/> Heterosexual | <input type="checkbox"/> Pansexual            |
| <input type="checkbox"/> Bisexual     | <input type="checkbox"/> Pomosexual           |
| <input type="checkbox"/> Homosexual   | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> Asexual      |   |

Comments:

5. What is your age?

6. Which race/ethnicity best describes you?

- American Indian or Alaskan Native
- Asian / Pacific Islander
- Black or African American
- Hispanic American
- White / Caucasian
- Other (please specify)

7. Which best describes your personal political affiliation?

- Republican
- Democrat
- Libertarian
- Green
- Independent
- Unaffiliated
- Decline to State
- Other (please specify)

8. Which best describes your personal religious affiliation?

- Protestant
- Catholic
- Other Christian
- Jewish
- Muslim
- Buddhist
- Agnostic
- Atheist
- Decline to State
- Other (please specify)

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## Practice Description

**In this section of the survey, you will be answering questions to provide us with a description of your employment setting, the clients you serve, and your clinical approach.**

9. Which of the following describes your primary employment setting?

- Private, For Profit
- Private, Nonprofit
- Public, Nonprofit
- Gov, State
- Gov, Local
- Other (please specify)

10. Which of the following best describes your primary employment setting?

- Hospital
- Educational
- Mental Health
- Child Welfare
- Private Practice
- Other (please specify)

11. How old is your typical client? (Check all that apply)

- 18 or Younger
- 18-25
- 26-36
- 36-46
- 47-54
- 55-64
- 65 or Older

12. What is the gender of your typical client? (Check all that apply)

- Women
- Men
- Transgender
- Other (please specify)

13. What is the sexual orientation of your typical client? (Check all that apply)

- Heterosexual
- Bisexual
- Homosexual
- Other (please specify)

14. Which of the following special populations categories describe your typical client? (Check all that apply)

- Homeless
- Elderly
- Ethnic Minorities
- Veterans
- Substance Abuse
- Other (please specify)

15. To what degree do the following approaches inform your clinical practice?

	Low	Medium	High	Specialty	N/A I do not use this approach
Psychodynamic (Object Relations,Ego Psychology, Attachment Theory,Self Psychology)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Behavioral (CBT,DBT, ACT,Operant Conditioning,Exposure Therapy)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Systems (Structural, Strategic,Functional Family Therapy)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eclectic (Bio-Psycho-Social,Strengths Based, Recovery Model)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

16. What is the average number of individual sessions your typical client is likely to use?

17. Are there any other clinical approaches that you use in your practice?

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### Addressing Sexuality in Practice

**Please answer the following questions based on your experience with clients in individual therapy.**

18. How important is addressing sexuality with the following client groups?

	Very Unimportant	Unimportant	Neither Important/Unimportant	Important	Very Important
Adjustment Disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anxiety Disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Depressive Disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Neuropsychological Disorders (ADHD, Asperger's, Autism)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Personality Disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Psychotic Disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Grief and Loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Interpersonal/Relationship Concerns	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sexual Dysfunction Disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

19. When are you most likely to address sexuality with your clients?

	During the 1st Session	By the 3rd Session	At Some Point After the 3rd Session	I will only discuss sexuality if my clients request to	I never discuss sexuality with my clients who present with this
Adjustment Disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anxiety Disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Depressive Disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Neuropsychological Disorders (ADHD, Asperger's, Autism)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Personality Disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Psychotic Disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Grief/Loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Interpersonal/Relationship Disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sexual Dysfunction Disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

20. When addressing sexuality with a client what factors do you consider? (Check all that apply)

- Sexual Orientation (e.g. Heterosexual, Bisexual...)
- Relationship Orientation (e.g. Monogamous, Polyamorous)
- Sexual Safety
- Pleasure
- Issues of Intimacy
- Body Image
- Alternative Forms of Sexual Expression (Fetishes)

Other (please specify)

21. When addressing sexuality in therapy which of the following do you use? (Check all that apply.)

- Behavioral Techniques
- Narrative Techniques
- Eclectic Techniques (Bio-psycho-social)
- PLISSIT Model (Permission, Limited Information, Specific Suggestions, and Intensive Therapy)

Other techniques/models (please specify)

22. How comfortable are you addressing sexuality with your typical client?

Very Uncomfortable	Uncomfortable	Neither Comfortable nor Uncomfortable	Comfortable	Very Comfortable
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

What factors, if any, affect your comfort level?

23. How would you rate your knowledge of the following?

	Low	Medium	High	This concept is my specialty	N/A I am not familiar with this concept.
Heterosexuality	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bisexuality	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Homosexuality	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Asexuality	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pansexuality	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Monogamy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Polyamory	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sexual Safety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pleasure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Issues of Intimacy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Issues with Body Image	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alternative Forms of Sexual Expression (Fetishes)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

24. How comfortable are you at addressing the following with your client?

	Very Uncomfortable	Uncomfortable	Neither Comfortable nor Uncomfortable	Comfortable	Very Comfortable	N/A I am not familiar with this concept
Heterosexuality	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bisexuality	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Homosexuality	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Asexuality	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pansexuality	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Monogamy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Polyamory	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sexual Safety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pleasure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Issues of Intimacy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Issues with Body Image	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alternative Forms of Sexual Expression (Fetishes)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

25. Professional Influences: To what degree do the following inform/influence how you address sexuality with your clients?

	Low	Medium	High	N/A Has no influence
Graduate Education	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Continuing Education	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Academic Education	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Work Place Trainings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Work Place Policy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Professional Journals and Articles	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

26. Personal Influences: To what degree do the following inform/influence how you address sexuality with your clients?

	Low	Medium	High	N/A Has no influence
Mass Media	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Religious and Spiritual Beliefs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cultural Beliefs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Personal Sexual Experience	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Personal Discomfort When Talking About Sex	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

[Prev](#) [Next](#)

Thank you!

**We greatly appreciate you taking the time to participate in our survey. Feel free to leave any additional input below.**

27. Please provide any other information regarding how you address sexuality in practice that you feel would be helpful or important to consider.

28. Do you have any other comments, questions, or concerns?

[Prev](#) [Done](#)



## Appendix C

## Institutional Review Board Approval Letter

CALIFORNIA STATE UNIVERSITY, SACRAMENTO

DIVISION OF SOCIAL WORK



To: Natalie Delfin &amp; Miriam Yelton

Date: December 12, 2014

From: Research Review Committee

**RE: HUMAN SUBJECTS APPLICATION**

Your Human Subjects application for your proposed study, "**An Exploration of How Sexuality is Addressed by Social Workers in Clinical Settings**", is **Approved as Exempt**. Discuss your next steps with your thesis/project Advisor.

Your human subjects Protocol # is: **14-15-043**. Please use this number in all official correspondence and written materials relative to your study. Your approval expires one year from this date. Approval carries with it that you will inform the Committee promptly should an adverse reaction occur, and that you will make no modification in the protocol without prior approval of the Committee.

The committee wishes you the best in your research.

Research Review Committee members Professors Jude Antonyappan, Teiahsha Bankhead, Maria Dinis, Serge Lee, Kisun Nam, Francis Yuen

Cc: Bankhead

Revised Sept 2014 ww

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