From social work to sex therapy: increasing clinicians' sexual intervention self-efficacy beliefs

Kijao Corbett

Follow this and additional works at: https://scholarworks.smith.edu/theses

Part of the Social Work Commons

Recommended Citation
Corbett, Kijao, "From social work to sex therapy: increasing clinicians' sexual intervention self-efficacy beliefs" (2017). Theses, Dissertations, and Projects. 1883.
https://scholarworks.smith.edu/theses/1883

This Masters Thesis has been accepted for inclusion in Theses, Dissertations, and Projects by an authorized administrator of Smith ScholarWorks. For more information, please contact scholarworks@smith.edu.
ABSTRACT

This study had two primary goals. The first was to learn what factors have aided sex therapists in increasing their perceived sexual intervention self-efficacy with adult clients. The second was to identify sex therapists’ suggestions for how Master’s of Social Work (MSW) programs might increase their students’ perceived sexual intervention self-efficacy. Data was collected via interviews with twelve clinical social workers who practice sex therapy. This study found that training and a stance of openness increased participants’ perceived sexual intervention self-efficacy. Participants suggested that MSW programs increase discussion about human sexuality; focus on teaching about the intersections of sexual diversity, culture, and identity; and give students tools to provide basic sexuality education to clients. The data also revealed that a majority of participants’ MSW programs did not prepare them to treat adult clients’ sexual concerns, and a lack of diversity and access in the sex therapy field.
FROM SOCIAL WORK TO SEX THERAPY: INCREASING CLINICIANS’ SEXUAL INTERVENTION SELF-EFFICACY BELIEFS

A project based upon an independent investigation, submitted in partial fulfillment of the requirements for the degree of Master of Social Work.

Kijai Katherine Corbett

Smith College School for Social Work
Northampton, Massachusetts 01063

2017
ACKNOWLEDGEMENTS

To my thesis advisor, Daniel O’Donnell, PhD, LMHC, thank you for spending Saturday mornings at the Florence Pie Bar with me all year, for your pep talks and careful edits, for reminding me to focus on this project as a learning process, and for insisting (despite my desire to never read or write anything ever again) that a doctoral dissertation is in my future.

To my family and friends, thank you for listening compassionately to my grumbling about lack of free time, for reminding me to take breaks (and naps!), for reading earlier drafts, and continually making me feel loved and supported.

To my classmates at the Smith College School for Social Work, thank you for commiserating and celebrating with me every step of the way.

Finally, deepest gratitude to the clinicians who participated in this study. I was blown away by your warmth and generosity in sharing your stories, your passion for and dedication to this work, and your encouragement for my research. I hope our lives will continue to intersect.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>ACKNOWLEDGEMENTS</th>
<th>i</th>
</tr>
</thead>
<tbody>
<tr>
<td>TABLE OF CONTENTS</td>
<td>ii</td>
</tr>
</tbody>
</table>

## CHAPTER

I  INTRODUCTION .................................................. 1

II  LITERATURE REVIEW ........................................... 6

III METHODOLOGY ................................................... 20

IV  FINDINGS .......................................................... 32

V  DISCUSSION ......................................................... 49

REFERENCES .................................................................. 57

## APPENDICES

Appendix A: Recruitment Post to AASECT Listserv .................................................. 62
Appendix B: Recruitment Email to Individual Clinicians ........................................... 63
Appendix C: Recruitment Post to Facebook ............................................................. 64
Appendix D: Participant Consent Form ................................................................. 65
Appendix E: Transcriber Confidentiality Form ....................................................... 67
Appendix F: Human Subjects Review Committee Approval Letter ......................... 68
Appendix G: Interview Guide ........................................................................... 69
CHAPTER I

Introduction

Of all the major health concerns and systems of our bodies, minds and hearts, sexuality is the least understood and the most trivialized. Sex is seen as frivolous, dangerous, sinful, self-indulgent, or solely a means to reproduce. Yet it can be a source of tremendous joy, intimacy, and spiritual connection if we heal the split that has been created by sex-phobia in our culture. I believe that we cannot have full healing, true wellness or real happiness until we delve into this part of ourselves. (Dischiavo, n.d.)

American culture is rife with conflicting messages about human sexuality. Sexuality is both public and private – it is ever present in American media and entertainment, yet also taboo to talk about the details of one’s own sexual reality.

The mental health profession in the United States is complicit in this lack of open dialogue about human sexuality. Research shows that the majority of mental health professionals are not being trained to address adult clients’ sexual concerns (Dermer & Bachenberg, 2015; Laverman & Skiba, 2012; Merritt, 2011; Reissing & Di Gulio, 2010; Schaub, Willis, & Dunk-West, 2017). Sexuality is a topic that is rarely included in clinical training programs and academic scholarship (Asher, 2007; Dermer & Bachenberg, 2015; Laverman & Skiba, 2012; McCave, Shephard, & Winter, 2014; Reissing & Di Gulio, 2010). When sexuality is addressed, it is usually in the context of cultural competence and anti-discriminatory practice with populations labeled “sexual minorities,” or individuals whose sexual identities and practices do not conform to the majority of the cultures in which they are located (Hicks, 2008; Jeyasingham, 2008).

Nonetheless, sexual health is intertwined with mental and physical health, and sexual pleasure has been shown to enhance quality of life (Laumann et al., 2006; Tenille, Solomon,
Bohrman, 2014; Timm, 2009). Despite lack of training, clinicians work frequently with clients for whom sexual concerns constitute significant quality of life concerns (Merritt, 2011; Reissing & Di Gulio, 2010; Schaub, Willis, & Dunk-West, 2017). Many clients may not bring up sexual concerns unless asked directly by clinicians or otherwise made to feel that the topic is permissible and appropriate. Research shows that clinicians who receive more education and supervision regarding human sexuality are more likely to initiate sexuality-related discussions with their clients (Harris & Hays, 2008).

This study is based on Miller and Byers’s (2012) concept of “sexual intervention self-efficacy.” Adapted from their definition, sexual intervention self-efficacy consists of the following:

A clinician’s belief that they feel comfortable discussing sexual issues and can recognize and decrease the likelihood of personal biases interfering with treatment; that they have the ability to relay accurate information about sexual issues; and that they are confident in their knowledge of and ability to utilize sex therapy techniques. (Miller & Byers, 2012)

It is important to note that self-efficacy refers to a person’s beliefs about their abilities; it does not necessarily correlate with actual abilities. Still, self-efficacy beliefs guide people’s choices and actions (Bandura, 1997). I use the term “perceived sexual intervention self-efficacy” or “sexual intervention self-efficacy beliefs” throughout this study.

Sex therapy is a discipline that has grown rapidly in the United States since the 1970s. Some of its popularity may be due to the fact that it fills a gap between some clinicians’ discomfort with sexuality-related discussions and their clients’ need to resolve sexual concerns (Binik & Meana, 2009). This study focuses on the perspectives of clinical social workers who practice sex therapy. This focus is informed by two assumptions: (a) that clinicians with a higher
degree of perceived sexual intervention self-efficacy will be more likely to address sexual issues
with their clients; and (b) that sex therapists are likely to have a higher degree of perceived
sexual intervention self-efficacy when compared to other clinicians. In addition, this study
focuses specifically on social workers because I am a clinical social worker and desire to add to
the knowledge base of the profession. This study also focuses on clinical practice with adults
(ages 18 and over) because sex therapy is an intervention primarily used with adult clients.

With that in mind, this study aims to answer the following questions: What are the factors
that aid sex therapists in increasing their perceived sexual intervention self-efficacy with adult
clients? What suggestions do sex therapists have for how Master’s of Social Work (MSW)
programs might increase their students’ perceived sexual intervention self-efficacy?

Drawing on Bandura’s (1997) work on the concept of self-efficacy, there has been a great
deal of research that evaluates the impact of self-efficacy beliefs in a variety of fields, including
education, medicine, and sports. Self-efficacy research in mental health professions has largely
been quantitative and focused on clinicians’ training. There has been little qualitative research
conducted about clinicians’ experiences of perceived self-efficacy, and fewer still about treating
clients’ sexual concerns. When qualitative research methods have been used, the focus has been
on clinical practice with populations considered sexual minorities, such as individuals who
identify as LGBQ (lesbian, gay, bisexual, queer) or practice polyamory or BDSM (Bondage and
Discipline, Dominance and Submission, Sadism and Masochism). Finally, while much has been
written about the history and current state of the field of sex therapy – and the controversy over
whether it should even be considered a distinct field (Berry, 2013; Binik & Meana, 2009;
Kleinplatz, 2003; Levine, 2003) – the voices of sex therapists are rarely included in the literature.
This study is qualitative and exploratory to discover new information about the perspectives and practices of social workers who identify as sex therapists. This research provides insight into how clinical social workers and other mental health professionals might increase their perceived sexual intervention self-efficacy when working with adult clients. In addition, this research identifies suggestions for social work programs interested in offering more comprehensive human sexuality training to their students.

The World Health Organization (WHO) asserts that human rights include sexual rights, such as the right to access sexual health services; receive information related to sexuality; and pursue a satisfying, safe, and pleasurable sexual life (WHO, 2006). The code of ethics for the National Association of Social Workers (NASW) states that social work’s mission is “to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty” (NASW, 2008). Clinical social workers have an ethical responsibility to provide the best possible care to their clients. Facilitating open dialogue, providing accurate and unbiased information, and increasing one’s own comfort and confidence when addressing clients’ sexual concerns is an integral part of supporting clients’ well-being and empowerment.

Definitions

Discussion about sexuality invariably brings up questions about the terms used. To preface this study, it is important to define what is meant by the following terms.

Sexuality. While sexuality is often conflated with sexual orientation, this study adopts the WHO’s broader definition:

Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction.
Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. (WHO, 2006, p. 5)

This study also refers specifically to “human sexuality” to underscore that this study’s focus excludes the sexual behavior of plants and animals.

**Sexual concerns.** For the purpose of this study, sexual concerns consist of anything that negatively impacts the sexual well-being of an individual or partners in sexual relationship. These may or may not include symptoms categorized as sexual dysfunctions by the Diagnostic and Statistical Manual of Mental Disorders (DSM), such as erectile disorder, female orgasmic disorder, or genito-pelvic pain.

**Sex therapy.** Here, sex therapy is any psychotherapy that focuses on treating clients’ sexual concerns and is facilitated by a clinician who identifies as a sex therapist.
CHAPTER II

Literature Review

Introduction

This chapter aims to demonstrate the need for qualitative research about clinicians’ development and understanding of their sexual intervention self-efficacy beliefs. This focus is informed by previous research demonstrating the lack of human sexuality training for social workers and other mental health professionals, as well as the significance of sexuality to clients’ well-being. The sex therapy field has grown in response to this gap between clients’ sexual concerns and clinicians’ expertise. There have been few qualitative studies that speak to clinicians’ sexual intervention self-efficacy beliefs, and fewer still that center the voices of sex therapists.

This chapter is organized by the following eight sections: (a) sources of self-efficacy beliefs; (b) factors influencing sexual intervention self-efficacy beliefs; (c) state of human sexuality training in the social work profession; (d) state of human sexuality training in other mental health professions; (e) suggestions for clinical training in human sexuality; (f) the importance of addressing human sexuality in clinical practice; (g) the stance of the social work field on human sexuality; and (h) perspectives on the sex therapy field.

Sources of Self-Efficacy Beliefs

Bandura (1997) conceptualizes self-efficacy as “beliefs in one’s capabilities to organize and execute the courses of action required to produce given attainments” (p. 3). According to Bandura (1997), self-efficacy beliefs are constructed from four possible sources of learning:
mastery experiences, vicarious experiences, verbal persuasion, and affective states. Researchers in a variety of fields have attempted to measure self-efficacy beliefs in order to predict and evaluate the impact of training interventions. For example, Pfitzner-Eden (2016) examines how preservice teachers integrate the four sources (mastery experiences, vicarious experiences, verbal persuasion, and affective states) when developing self-efficacy beliefs during a school practicum. The researcher collected data from two samples of German preservice teachers: 359 beginning teachers at an early stage in their bachelor’s degree and 395 advanced teachers enrolled in either the master’s degree or in the last year of their bachelor’s degree. Results showed that changes in self-efficacy for both groups were most significantly predicted by mastery experiences. In addition, mastery experiences were informed by the other three sources to varying degrees depending on the type of teaching practicum.

Additionally, Daniels and Larson (2001) examine the impact of performance feedback on self-efficacy beliefs and anxiety for counselors. Forty-five graduate-level counselor trainees participated in mock counseling sessions and received randomly assigned positive or negative feedback. The researchers found that participants translated positive feedback as a mastery experience and that this mastery experience led to increased counseling self-efficacy and decreased anxiety. Likewise, negative feedback led to decreased counseling self-efficacy and increased anxiety. The researchers highlight the importance of providing multiple opportunities for trainees to have mastery experiences in order to develop as efficacious counselors. These studies suggest that mastery experiences involving positive performance feedback may also be important factors in increasing self-efficacy for sex therapists.
Factors Influencing Sexual Intervention Self-Efficacy Beliefs

Harris and Hays (2008) measure sexual intervention self-efficacy in terms of the likelihood that clinicians will initiate sexuality-related discussions with their clients. The researchers surveyed 175 clinical members of the American Association for Marriage and Family Therapists to determine to what extent sexuality education and supervision experience, clinical experience, therapist-perceived sexual knowledge, and therapist comfort with sexual topics influenced therapists’ willingness to engage in sexuality-related discussions with their clients. The researchers found that sexuality education and supervision experience addressing sexuality were the best predictors of therapists initiating sexuality-related discussions with their clients – as sexuality education and supervision experience increase, therapist-initiated sexuality discussions also increase. The study found no significant difference in results based on gender or education level, though they did find that respondents who reported being certified as sex therapists were more likely to initiate sexuality discussions with clients. Harris and Hays’s (2008) findings demonstrate the importance of human sexuality education for clinicians and also underscore the need to investigate how that education is structured. The researchers conclude that increasing personal comfort with sexual content is more important for clinicians than perceiving themselves as knowledgeable about sexual topics, therefore sexuality education must incorporate methods that facilitate increased comfort with sexual topics.

In a series of studies, Miller and Byers (2008, 2010, 2012) investigate the development of what they term sexual intervention self-efficacy beliefs. In their 2012 study, the researchers surveyed 110 practicing clinical psychologists in Canada and the United States to assess whether clinicians with more graduate-level human sexuality education engage in more continuing sexuality education post-training, and result in higher sexual intervention self-efficacy beliefs.
and greater willingness to address clients’ sexual concerns. They found that clinicians with more
graduate-level sexuality education do indeed engage in more sexuality education post-training,
and that more sexuality education results in higher self-efficacy beliefs. Furthermore, clinicians
who had more sexuality education reported asking about and treating sexual issues with therapy
clients more frequently and were more willing to treat rather than to refer out clients with sexual
concerns. Contrary to the researchers’ hypotheses, these findings held equally true of clinicians
with conservative and liberal attitudes toward sexuality and for clinicians who were more or less
comfortable discussing sexuality topics. Results also indicated that sex education appears to
increase sexual intervention self-efficacy regardless of whether it occurs in graduate school or
post-internship. This study suggests that human sexuality training, whether in a graduate
program or through continuing education, may be a primary factor in increasing sexual
intervention self-efficacy beliefs for clinicians.

Risen (1995) describes the following barriers that mental health professionals face when
taking a client’s sexual history: lack of knowledge outside of one’s own experience; fear of the
affects generated by such a discussion; and awkwardness with sexual language. The author
suggests several ways to increase knowledge and comfort in discussing sexual issues clinically,
including role playing, analyzing sexual histories in case conferences, reading and discussing the
current body of knowledge regarding sex, trying out interventions in detail with supervisors, and
observing more experienced therapists take sexual histories.

State of Human Sexuality Training in Social Work Profession

While the preceding research highlighted the importance of human sexuality training for
clinicians, studies show that such training for social workers is often unavailable or inadequate.
Laverman and Skiba (2012) note that, in the decades since the 1960s, social work educators have
recommended the inclusion of human sexuality content into social work curricula. To determine whether present-day students have been equipped to address clients’ sexual concerns, the researchers surveyed a total of 170 senior Bachelor’s of Social Work (BSW) students from eight programs within a state in the northeastern United States. The research purpose was to gauge the students’ ability to identify sexuality content within their undergraduate curriculum, their sense of preparedness to address future clients’ sexual concerns, and their perception regarding the extent of their future work with clients who present with sexual concerns. The researchers found that only 50% of the students could identify human sexuality content as a unit in a required course and less than 50% reported that they felt adequately prepared to handle most areas of human sexuality in their future work. At the same time, 74% of students expected to work with clients who might present with sexual concerns. This study suggests that the human sexuality education available to current BSW students may fail to prepare them to address sexual issues in future clinical work.

Similarly, Merritt (2011) found that 90 master’s-level clinical social workers who had graduated from the Smith College School for Social Work reported receiving little or no training in human sexuality during graduate school or post-graduation. Only 51% of participants reported having taken either an undergraduate or graduate course on human sexuality. In addition, 56% reported never having taken continuing education courses on human sexuality post-graduation. Of those who did report having received some form of human sexuality training, only 18% reported having taken a comprehensive human sexuality course in their MSW program. Despite this, 82% of participants reported addressing sexuality-related issues with clients and 83% reported that having sexuality-related discussions with clients could provide therapeutic value. When asked what barriers might prevent clinicians from feeling comfortable
in having discussions about sexuality with their clients, the two most frequently reported barriers were lack of training (60%) and racial or cultural differences (43%).

Schaub, Willis, and Dunk-West (2017) explore how social workers’ perceptions about sexuality shape their interactions with clients and colleagues. In a recent study conducted in the United Kingdom, the researchers surveyed 112 registered social workers. 92% of participants agreed that social workers need to know about sexuality to conduct their work and 48% agreed that sexuality was important in their current role. 75% reported confidence in their knowledge about sexuality and 58% reported that they felt comfortable discussing sex and sexuality with clients. At the same time, 56% indicated that their degree did not equip them with adequate knowledge about human sexuality and 90% reported no additional sexuality-specific training. This study suggests that while many social workers in the United Kingdom feel knowledgeable and comfortable addressing sexual issues with clients, they may derive this capacity from sources other than formal education or professional training.

State of Human Sexuality Training in Other Mental Health Professions

Dermer and Bachenberg (2015) emphasize the importance of training marital, couple, and family therapists in sexual health. The researchers reviewed the curriculum of 42 programs with specializations in marital, couple, and family counseling and found that only 52% required a course in sexuality. They note that sexual health is often discussed in terms of negative sexual rights (e.g. freedom from violence, freedom from sexually transmitted infections), rather than on positive rights (e.g. the right to sexual pleasure, the right to sexual expression).

Reissing and Di Giulio (2010) surveyed 188 practicing clinical psychologists treating adults in Canada to determine the extent to which they encountered sexual health concerns in their practice and what, if any, barriers they experienced in addressing those concerns. While
more than half of the participants reported discussing sexual health topics with their clients (most frequently safer sex practices and desire discrepancies in couples), more than half of the participants reported that they had not received formal education or supervised clinical training in sexual health issues. Moreover, 60% of clinicians reported that they asked sexual health questions “a few times” or “not at all” in their practice. The researchers concluded that lack of training affected clinicians’ comfort levels, which may result in either inadequate application of sex therapy treatment or no treatment at all. Reissing and Di Giulio (2010) recommend the inclusion of sexuality-related topics in existing clinical graduate courses and broader options for continuing education for practicing clinical psychologists. In addition, the study found that psychologists who were 40 years old or younger reported more comfort with discussing sexual health concerns but did not report more training compared with senior clinicians. This may indicate that clinicians’ comfort with sexual interventions is related to generational and cultural influences, as well as to education and training.

Asher (2007) evaluates the level of training and exposure students in clinical psychology, counseling psychology, and social work doctoral programs receive about human sexuality, sexual dysfunction, and sex therapy. In particular, the study focuses on how training in sexuality has changed over the twenty years since a similar study was conducted in the 1980s. The researcher surveyed training directors of 67 graduate programs in the United States, including 41 clinical psychology programs, 21 counseling psychology programs, and 4 social work programs. While only 24% of the programs reported no training in any areas of sexuality, counseling psychology programs offered less training than clinical psychology programs, and the social work programs reported that they did not offer clinical training in any areas because they were research-based programs.
Suggestions for Clinical Training in Human Sexuality

In a mixed methods study examining medical education discourse and autoethnographic research, Sloane (2014) determines that doctors and social workers face similar barriers to discussing sexuality because of a lack of professional training, lack of exposure to diverse sexualities, a sense of embarrassment, and concern about professional ethics. Sloane (2014) asserts, “Without direct formal education, social workers, like the general public, rely on knowledge, skill, and attitudes that are the result of limited personal experience, sex education as adolescents, and representations of sex in popular culture” (p. 459). The researcher argues for expanded social work education that emphasizes developing knowledge of sexuality as a complex concept, encouraging a client-centered attitude toward sexuality, and building skills of open communication. Sloane also asserts that sexual pleasure is an integral part of well-being and encourages social workers to serve as allies in ending discriminatory practices that create barriers to sexual pleasure.

Timm (2009) challenges the reasons that couples therapists give for not asking clients about their sexuality, and also offers suggestions to equip therapists to do so. Timm (2009) notes that sexuality issues are important for couples therapists to address because of the prevalence of sexual difficulties; the fact that sexuality is an integral part of romantic relationships; that sexual health influences quality of life; and that sexual dysfunction can be an indicator of physical health problems. The author concludes that many couples therapists fail to address sexuality due to lack of training; self-of-therapist issues (including comfort level, the messages the therapist received about sexuality in their family of origin, and the therapist’s personal history of sexual relationships); and the division in disciplines between couples therapy and sex therapy. The author states, “In general, training in sex therapy requires little to no training or supervision in
couple issues and vice versa” (Timm, 2009, p. 18). Timm describes the use of the PLISSIT (Permission, Limited Information, Specific Suggestions, Intensive Therapy) model to provide varying levels of intervention for clients’ sexual concerns. The author also offers suggestions to increase therapists’ comfort level, including reading or attending workshops on basic human sexuality; examining self-of-therapist issues (by completing a sexual genogram, sexuality timeline, or Sexuality Attitude Reassessment (SAR) training; finding support, and practicing.

Sitron and Dyson (2009) examine historical efforts to measure the efficacy of SAR training. SAR training was developed in the United States in the 1970s and has been used since as a routine training method for sexuality professionals. It is required by organizations such as the American Association of Sexuality Educators, Counselors, and Therapists (AASECT) for professional certification. Goals of SAR training include “to develop professionals’ awareness of sexual diversity, to increase self-understanding, to develop comfort with difference and sexuality from the perspective of others, and to promote nonjudgmental and empathic practice” (Sitron & Dyson, 2009, p. 168). The authors assert that instead of changing specific attitudes, SAR training can assist sexuality professionals in developing self-awareness of their sexological worldviews and broaden their scope toward relativist, humanistic, and pluralistic practice. Sitron and Dyson (2009) define sexological worldview as,

the often unexamined but changeable perspective held by each person about the world around them with regards to sexuality; it is the result of the socialization process that is comprised of values, beliefs, opinions, attitudes, and concepts specific to sexuality, including any and all sexual behavior and identities. (Sitron & Dyson, 2009, p. 173)

Finally, Graham and Smith (1984) develop an operational definition for the concept of “sexuality comfort” for sexuality educators, noting that sexuality comfort in educators directly
influences the effectiveness of their teaching. The researchers interviewed 32 high school and college sexuality educators. Results led to the delineation of a two-part operational definition of sexuality comfort – one part describing evidence of sexuality comfort in sexuality educators; the other addressing sexuality comfort as a developmental task. For the development of sexuality comfort, the authors state that experiences must “improve self-understanding; desensitize; improve understanding/tolerance of divergent sexualities; improve communication skills; improve teaching competencies; increase one’s knowledge base about sexuality; and involve exposure to a role model of sexuality comfort” (Graham & Smith, 1984, p. 440). The researchers suggest that sexuality educators be required to complete a methods course that focuses on three components of sexuality comfort: sexual feelings and attitudes; respect and acceptance for others; and communication skills. They note that sexuality communication issues include the ability to communicate, the willingness to communicate, and the ease with which one communicates.

**Importance of Addressing Human Sexuality in Clinical Practice**

Tenille, Solomon, and Bohrman (2014) describe the challenges that persons with psychiatric disabilities can face in achieving sexual expression – from the effects of psychotropic medications on sexual arousal to the paternalistic attitudes of service providers. They note that social workers are proportionately the largest provider of mental health services in the United States, and therefore are poised to lead the effort in addressing the sexuality and intimacy concerns of clients with psychiatric disabilities. The authors stress the need for changes to social work curricula and argue, “by pedagogical omission, social work education has linked sexuality and intimacy to privilege and, without intending to, reified oppressive dominant discourses” (Tenille, Solomon, & Bohrman, 2014, p. 473). The authors also present a pedagogical model
based on a recovery movement framework and motivational interviewing techniques to assist the
field instructor-social work student dyad in addressing sexuality and intimacy.

**Stance of the Social Work Field on Human Sexuality**

McCave, Shepard, and Winter (2014) emphasize the social work field’s historic
ambivalence about scholarship on human sexuality. The researchers examine the history of
social work scholarship on human sexuality. They found that the sole academic journal on social
work and human sexuality was discontinued in 1993; there are no social work textbooks on
human sexuality published for social work educators in the United States; and there is a lack of
sexuality-focused research and teaching scholarship presented at the two major social work
conferences. The authors propose that the taboo of human sexuality limits a cohesive
professional discourse and argue the need to advance the social work knowledge base in order to
support client self-determination in negotiating their sexual selves.

Rowntree (2014) conceptualizes sexuality as a social axis (rather than a social category
or social identity) in a matrix of other intersecting axes (such as race, class, and gender) that
constitute an individual’s sense of self. Sexuality thus encompasses people’s everyday desires,
practices, relationships, and identities. The author notes the lack of analysis of sexuality as a
social axis in the Australian social work curriculum and argues that this is due to the implicit
heteronormative assumptions of the field’s ideas and practices.

**Perspectives on the Sex Therapy Field**

Levine (2009) discusses the history of sex therapy as a practice that originally aimed to
treat sexual dysfunction in heterosexual couples. The author delineates his own professional
trajectory as a psychiatrist who identified as a sex therapist in the 1970s but later rejected that
title and now defines himself as a specialist in clinical sexuality. He argues that sex therapy has
no “substantial viable cohesive basis” rooted in research and that the term is meaningless, “unless, of course, by sex therapy we mean all things involving any aspect of sexuality brought to our clinical attention” (Levine, 2009, p. 1033).

Kleinplatz (2003) discusses three major trends in sex therapy: the prevailing conception of sex therapy as treatment of symptoms of sexual dysfunction and disorders; the growing medicalization of sexuality, sexual problems, and their treatment; and the fragmentation of the field. The author notes that the demise of the field of sex therapy is reflected in the decrease of clinicians who identify as sex therapists, as evidenced by the records of the American Association of Sex Educators, Counselors, and Therapists (AASECT). Kleinplatz (2003) points to similar membership declines in the Society for the Scientific Study of Sexuality (SSS) and the Society for Sex Therapy and Research (SSTAR), which both have international membership. Kleinplatz (2003) laments the effect these trends have on patients:

One cannot count on seeing a clinician who has received a fundamental core of training in the biological, psychological, interpersonal and social aspects of human sexuality. More patients are likely to be directed to medical intervention given that pharmaceutical companies profit from the belief that sexual problems are based in organic disorders. (p. 103)

The author concludes, "The early accomplishments of sex therapy have paradoxically led us to our current status, as a field with little solid foundation and a dubious future" (p. 103).

Binik and Meana (2009) argue that sex therapy is not sufficiently different from other forms of psychotherapy to be considered a specialty. They assert that sex therapy lacks a unifying theory, unique modes of delivery, defining techniques, and superior outcome efficacy. The authors suggest that the popularity of sex therapy is due, in part, to the fact that it provides
clinicians with a convenient referral source that allows them to forego facing their own discomfort with clients’ sexual concerns. They assert, “If sex, the very activity that perpetuates human life, is a source of paralyzing anxiety for a would-be mental health practitioner, then something is wrong with our professional training” (p. 1023). The authors recommend that all clinicians receive training on the treatment of sexual dysfunction, just as they receive training in treating conditions like depression or anxiety; that the certification of sex therapists be discontinued; that clinicians begin to treat sexual dysfunction through a concurrent multidisciplinary model; and that the field reengage in randomized controlled research on biopsychosocial treatments of sexual dysfunction.

Schwab (2014) examines the joys and challenges of sexuality educators, therapists, and researchers to determine what leads professionals to enter, practice, and remain in the field of human sexuality. The researcher interviewed 27 leaders in the field, 16 of whom identified either solely as sex therapists or a combination of therapist and educator or therapist and researcher. Sex therapists reported experiencing joy from the overwhelming trust of their clients and the variety of presenting problems in their clinical practice. Sex therapists’ challenges included possessing insufficient training and struggling with clients’ beliefs about sexual normality. The researcher notes that the issue of insufficient training is related to the fact that there is no universally standardized coursework or supervision requirement among credentialing bodies for the training of sex therapists. Participants identified goals for the future of the field, including standardizing sex therapy certification and moving toward a more holistic focus on pleasure in therapy.
Summary

This chapter presented an overview of previous research on the impact of self-efficacy beliefs on clinical performance, the value of addressing human sexuality in both clinical education and practice, and the role of sex therapy in the mental health professions. There have been few in-depth, qualitative discussions with clinicians about the relevance of human sexuality to clinical education and practice. The present study aims to address this gap in the literature by centering the perspectives of clinical social workers who practice sex therapy.
CHAPTER III

Methodology

Research Purpose and Design

The purpose of this study was to answer the following questions: What are the factors that aid sex therapists in increasing their perceived sexual intervention self-efficacy with adult clients? What suggestions do sex therapists have for how Master’s of Social Work (MSW) programs might increase their students’ perceived sexual intervention self-efficacy?

This study was exploratory in order to gain new insight into a population (sex therapists) and a phenomenon (sexual intervention self-efficacy beliefs) that has been little studied. According to Engel and Schutt (2017), “Exploratory research seeks to learn how people get along in the setting under question, what meanings they give to their actions, and what issues concern them” (p. 12). This study sought to learn how sex therapists have increased their sexual intervention self-efficacy after being trained as social workers, and their suggestions for the training of future social workers. The intended audience includes social workers interested in increasing their own perceived sexual intervention self-efficacy, and social work educators interested in providing more comprehensive human sexuality training.

Because the goal of the study was exploration, qualitative methods and inductive research were used to develop theory based on the data collected. As Engel and Schutt (2017) write, “Qualitative researchers typically begin their projects seeking not to test preformulated hypotheses but to discover what people think, how they act, and why, in some social setting” (p. 258).
The study followed a phenomenological approach. According to Creswell (2007), “A phenomenological study describes the meanings for several individuals of their lived experiences of a concept or a phenomenon. Phenomenologists focus on describing what all participants have in common as they experience a phenomenon” (Creswell, 2007, p. 58).

This study was also influenced by a constructivist worldview. Engel and Schutt (2017) write, “Constructivist social scientists believe that social reality is socially constructed and that the goal of social scientists is to understand the meanings people give to reality, not to determine how reality works apart from these constructions” (p. 16). In addition, Creswell (2007) notes, “[Constructivist] researchers make an interpretation of what they find, an interpretation shaped by their own experiences and background. The researcher’s intent, then is to make sense (or interpret) the meanings others have made about the world” (p. 21).

At the same time, this study aims for the transformative paradigm proposed by Mertens (2012). The goal of the transformative paradigm is to promote social justice. Mertens (2012) notes that while constructivists hold that realities are socially constructed, researchers situated in a transformative paradigm do not assume that those realities are all equally valid. Instead, “The transformative axiological assumption situates a researcher’s ethical stance squarely in the position of promoting social justice. To this end, versions of reality are critically examined to determine whether they advance or inhibit the furtherance of social justice” (p. 80). Finally, “qualitative researchers situated in the transformative paradigm begin with the intent of uncovering barriers to and proactive forces for social justice” (Mertens, 2012, p. 65).

Sample

The population sample consisted of twelve social workers who have significant clinical experience and training in sex therapy. Inclusion criteria for participation included: possessing a
master’s degree in social work; holding a valid state license to practice social work; at least two years of post-degree experience practicing direct clinical social work; experience providing treatment, as the sole or primary clinician, to a minimum of three adult clients (age 18 and up) in the past twelve months whose presenting concerns included sexual issues; completion of post-degree clinical education or training in human sexuality; self-identification as a provider of sex therapy; and agreement to participate in the study. Potential participants were excluded if they did not agree to participate in the study.

This study used nonprobability purposive sampling methods. Engel and Schutt (2017) note, “A purposive sample may be a key informant survey, which targets individuals who are particularly knowledgeable about the issues under investigation” (p. 121). I recruited participants in the following ways:

1. As a student member of the American Association of Sexuality Educators, Counselors, and Therapists (AASECT), I posted a recruitment request on the AASECT listserv (see appendix A).

2. I emailed individual clinicians who were listed in public referral directories on the websites of the following organizations: AASECT; the Society for Sex Therapy and Research (SSTAR); the National Coalition for Sexual Freedom; and Psychology Today (see appendix B).

3. I posted an announcement on my personal Facebook page, as well as to three closed Facebook groups for students and alumni of the Smith College School for Social Work (see appendix C).
4. I asked local professionals to forward my recruitment email. These professionals included: the eastern region representative for AASECT; the director of a local clinic that offers sex therapy; and colleagues at my field placement.

Recruitment materials listed the requirements for participation. Potential participants were asked to contact me directly via phone or email if interested. Potential participants who indicated an initial interest were emailed the consent form to sign and return before the interview (see appendix D). They were also asked how they would prefer to be interviewed (in-person, by phone, or online), what days and times would work best for an interview, and whether they had any questions about participating in the study. Follow-up emails were sent one or two times to potential participants who indicated initial interest and then did not respond. Due to the study time constraints and the volunteer nature of participation, if I did not hear back from participants, I assumed that they were not interested in participating and no further attempts were made to recruit them.

There are several limitations to this sampling approach. Due to the study time constraints and the convenience of a local professional network, recruitment efforts were concentrated in Massachusetts’s Hampshire County where the researcher is located. The 2010 census identifies the county’s population as 89% White (U.S. Census Bureau, 2010). Focusing recruitment efforts on this region likely limited the racial diversity of the sample. Participants from the same geographic region may also share other characteristics or viewpoints not reflective of a broader sample. Participants who responded from the AASECT listserv were drawn from a national base and thus more geographically diverse, but not necessarily more diverse in others aspects of identity (such as race, ethnicity, class, socioeconomic status, indigenous heritage, etc.). A 2002 survey conducted by the National Association of Social Workers (NASW) found that a majority
of its regular members identify as White/Caucasian (87%), as well as female (79%) (NASW, 2003). Due to the study’s requirements that participants have completed both master’s degrees and post-degree training in human sexuality, it is likely that many participants also had a high degree of socioeconomic privilege that allowed them to attain that education. Potential participants were accepted on a first-come, first-served basis and attempts were not made to actively recruit a more diverse sample after the minimum sample size was reached. Nonetheless, as the minimum sample size of twelve participants was close to being met and the final few interviews completed, the data appeared to reach saturation – “the point when new interviews seem to yield little additional information” (Engel & Schutt, 2017, p. 277).

**Ethics and Safeguards**

Prior to recruitment of participants for this research, approval for the study and all safeguards to ensure ethical standards were obtained from the Smith College School for Social Work Human Subjects Review Committee (see appendix F). Participants were informed of the potential risks and benefits of participation, as well as their right to discontinue participation or withdraw from the study at any time up to seven days after the interview was conducted. Participants were also informed of their right to ask questions or report concerns at any time before, during, or after the research.

The risk to participants consisted of a slight possibility that they might feel distress while considering their professional experiences and assessing their own degree of perceived sexual intervention self-efficacy. Participants were not required to discuss any experiences they did not want to discuss. As a clinician in training and aware of non-verbal signs of discomfort or distress, I monitored interviewees to reduce the likelihood of participant distress. I also informed all participants that they could decline to answer any question or end the interview at any time.
for any reason. All participants were experienced clinicians themselves. As such, they were aware of and had access to resources and support systems needed to practice self-care during and after the interview. The benefits of participation consisted of having an opportunity to discuss an area of clinical interest and to contribute to research that may prove useful to the fields of social work and sex therapy. No compensation was provided to participants.

Participation in this study was not anonymous because of the nature of conducting individual interviews. However, steps were taken to ensure the confidentiality of participants and their responses to research questions. In-person interviews were conducted in participants’ offices or homes. For phone and online interviews, I was located in my office or home and participants chose a location for themselves that provided quiet. Individual quotes that are used to illustrate findings are presented in a manner that does not identify any individual. All data is reported in aggregate format.

I used an Olympus VN-722PC digital voice recorder to capture participants’ responses during interviews conducted in-person, on the phone, and over FaceTime. I used Ecamm Call Recorder for Skype to record video files of Skype interviews. I also jotted down brief notes during the interviews to capture key points and to help guide the interview. Audio files were transferred from the digital recorder to my personal computer via a USB cable. Audio files were erased from the digital recorder once transferred. Electronic files, including audio and video recordings, were stored in computer folder encrypted with Viivo software. Consent letters and other paper records were kept in a locked file cabinet. I mailed a hand-written thank you card to each participant after each interview and included a copy of the consent form signed by both the participant and the researcher.
All research materials – including recordings, transcriptions, analyses, and consent documents – will be stored in a secure location for three years according to federal regulations. All electronically stored data will be password-protected and encrypted during the storage period.

**Data Collection**

Data was collected through semi-structured interviews that lasted an average of 45 minutes and were audio or video-recorded. Participants were interviewed individually either in-person, by phone, or online (via Skype or FaceTime). For interviews that took place in-person, the location was collaboratively determined.

I created the interview guide (see appendix G). Participants were first asked background questions about how they came to practice sex therapy and about their training in human sexuality. Following this, participants were asked a series of questions about how they had increased components of sexual intervention self-efficacy beliefs (e.g. personal comfort). Finally, participants were asked whether they believed their MSW program adequately prepared them to treat adult clients’ sexual issues, and for their suggestions as to how MSW programs might increase their students’ sexual intervention self-efficacy. After these questions, participants were invited to share any additional thoughts that had not yet been covered in the interview. At the end of each interview, participants were asked to provide verbal answers to eight demographic questions, which asked them to identify their age, gender, sexual orientation, race/ethnicity, religious/spiritual affiliations, current primary professional role, number of years practicing sex therapy, and number of adult clients with sexual issues treated in the last twelve months.
Each interview recording was transcribed verbatim. Seven of the interviews were transcribed by the researcher. Five of the interviews were transcribed by Rev.com, a professional transcription service provider. Before being given access to the recordings, Rev.com signed the Transcriber Confidentiality Form (see appendix E) and also provided a copy of their Client Non-Disclosure Agreement. Electronic files were uploaded to Rev.com’s website, after which the company stored and transmitted the files using TLS 1.2 encryption. I read through each transcribed interview methodically to check for accuracy.

Data Analysis

Thomas (2003) outlines a general inductive approach for qualitative data analysis that uses the following steps:

1. Initial read through text data
2. Identify specific segments of information
3. Label the segments of information to create categories
4. Reduce overlap and redundancy among the categories
5. Create a model incorporating most important categories. (p. 6)

Through this approach, Thomas (2003) notes, many pages of text are eventually sorted into three to eight categories (p. 6). This general inductive approach accurately reflects my own process of data analysis. Interview transcripts were read repeatedly to identify codes. Using Dedoose – a data analysis program for qualitative and mixed methods research – I created excerpts by highlighting segments of text that were applicable to one or more codes. Movement between step four (reduce overlap and redundancy among the categories) and step five (create a model incorporating most important categories) proved to be cyclical, as I continually refined categories while writing the following chapter on the study’s findings. Categories were linked.
and combined when the meanings were similar and overlapping codes were condensed into upper-level or more general codes. Contradictory and outlier statements were included in the corresponding categories. Using Dedoose, I created code application charts, which I used to count the number of participants associated with each code. Creswell (2007) writes about the issues involved in counting codes in qualitative research:

Some (but not all) qualitative researchers feel comfortable counting and reporting the number of times the codes appear in their databases. It does provide an indicator of frequency of occurrence, something typically associated with quantitative research or systematic approaches to qualitative research. In my own work, I may look at the number of passages associated with each code as an indicator of participant interest in a code, but I do not report counts in my articles. This is because counting conveys a quantitative orientation of magnitude and frequency contrary to qualitative research. In addition, a count conveys that all codes should be given equal emphasis and it disregards that the passages coded may actually represent contradictory views. (p. 152)

In this study, I chose to count codes because doing so allowed me to visualize and emphasize the themes that appeared important to a majority of the participants. This also seems consistent with the goals of a phenomenological study in “describing what all participants have in common as they experience a phenomenon” (Creswell, 2007, p. 58). That said, I chose to report additional findings that appeared significant despite being cited less frequently by participants.

While content analysis and thematic analysis are frequently cited interchangeably in qualitative research literature, Vaismoradi, Turunen, and Bondas (2013) discuss the differences between the two. They write,
By using content analysis, it is possible to analyze the data qualitatively and at the same time quantify the data. Content analysis uses a descriptive approach in both coding of the data and its interpretation of quantitative counts of the codes. Conversely, thematic analysis provides a purely qualitative, detailed, nuanced account of data. (Vaismoradi, Turunen, & Bondas, 2013, p. 400)

According to the definition provided by the authors, this study uses content analysis because it reports and interprets quantitative counts of codes.

**Study Limitations**

There are several limitations to this study. First, interviews were not anonymous and the participants may have been less likely to be honest or reveal more vulnerable information than if the study had provided anonymity. Second, similar to other studies, this study relies on clinicians’ memories about past professional and educational experiences (Miller & Byers, 2012). The greater the length of time between the interview and the experience recalled, the more difficult it may be for clinicians to access accurate memories. Third, the findings of this study will not be transferable to another population or context. As Engel and Schutt (2017) write:

> Explanations derived from qualitative research will often be richer and more finely textured than the explanations resulting from quantitative research, but they are likely to be based on fewer cases from a limited area. We cannot assume that the people studied in this setting are like others or that other researchers would develop explanations similar to ours to make sense of what was observed or heard. (p. 40)
Researcher Bias and Positionality

It seems important to reflect on my own position as the researcher. Drisko (2013) writes, “Because the researcher is the key ‘tool’ in qualitative research, explicitly identifying sources of potential researcher bias strengthens the credibility of qualitative reports” (p. 27-28). From the outset, I chose this research topic because I am interested in practicing sex therapy. I believe that sexuality is an important part of life for both clinicians and clients and that it should be discussed more often and more comprehensively in social work practice and education. Based on my review of the literature, my personal experience during my MSW education, and informal conversations with peers, one of my initial expectations for the study was that participants would report that their MSW programs had not adequately prepared them to treat adult clients’ sexual concerns.

In addition, Engel and Shutt (2017) write, “Qualitative researchers recognize that their perspective on social phenomena will reflect in part their social background and current situation. Who the researcher is and ‘where he or she is coming from’ can affect what the research finds” (p. 259). To provide context for this study and its findings, I offer the following description of my social background and, in doing so, provide answers to the same demographic questions I asked of participants in this study. I identify as an African-American, queer, cisgender woman in my thirties. I am interested in many spiritual practices and do not ascribe to an organized religion. I do not have any major visible or invisible disabilities. I cannot trace my ancestors’ origins back further than the 1800s because families and communities were torn apart during the enslavement of African peoples in the Americas. I grew up in the Midwestern United States and have lived in several regions of the country as an adult. I am pursuing my master’s
degree in social work and both of my parents earned graduate degrees. I have had a great deal of educational and socioeconomic privilege throughout my life.
CHAPTER IV

Findings

This study had two primary goals. The first was to learn what factors have aided sex therapists in increasing their perceived sexual intervention self-efficacy with adult clients. This study found that training and a stance of openness increased participants’ perceived sexual intervention self-efficacy. The second goal was to identify sex therapists’ suggestions for how Master’s of Social Work (MSW) programs might increase their students’ perceived sexual intervention self-efficacy. Overall, participants suggested that MSW programs increase discussion about human sexuality; focus on teaching about the intersections of sexual diversity, culture, and identity; and give students tools to provide basic sexuality education to clients.

Two additional themes emerged from the data. One, a majority of participants stated that their MSW programs did not prepare them to treat adult clients’ sexual concerns. Two, participants emphasized a lack of diversity and access in the sex therapy field.

This chapter will present these findings and then conclude with information about the sample’s demographics.

Training and a Stance of Openness Increased Perceived Sexual Intervention Self-Efficacy

As defined in this study, perceived sexual intervention self-efficacy is comprised of four components. Participants were asked the following four questions regarding their perceived sexual intervention self-efficacy:

1. *What has increased your personal comfort discussing sexual issues with adult clients?*
2. What has increased your ability to recognize and decrease the likelihood of personal biases about sexuality from interfering with the treatment you provide?

3. What has increased your ability to relay accurate information about sexual issues to adult clients?

4. What has increased your confidence in your knowledge of and ability to utilize sex therapy techniques?

In addition, participants were asked a fifth question: At times, if any, that your sexual intervention self-efficacy has decreased, what have you done to recover and increase it?

Participants’ responses to each of the five questions tended to repeat across the different components of perceived sexual intervention self-efficacy. For example, nine of the 12 participants cited supervision and peer consultation at least once in response to each of the five questions – one participant regarding personal comfort; five regarding recognizing biases; three regarding accurate information; four regarding confidence; and seven regarding recovering and increasing these components. Therefore, the following data is compiled from responses across all five questions rather than separated into each individual question.

Factors that increased participants’ perceived sexual intervention self-efficacy can be categorized by two broad themes: (a) training, and (b) a stance of openness. Within these two themes, several subthemes emerged, which are listed below.

Training.

Continuing education. All 12 participants mentioned the importance of continuing education. For the purpose of this study, continuing education includes any training, research, reading, or conference attendance completed outside of an academic degree program. Continuing education may also have been completed as part of the requirements for certification
by the American Association for Sex Educators, Counselors and Therapists (AASECT).

Regarding continuing education, participants mentioned attending sexuality presentations and workshops; reading published work on sexuality in clinical practice; following the AASECT and Society for Sex Therapy and Research (SSTAR) member listservs; and following social media and journalism. One participant highlighted the abundance of material relevant to sex therapy practice:

Conferences, books, film, art – anything that exposes me. You know, you don’t have to look far to see sexuality. And it doesn’t always have to be a lecture with a donut and a cup of coffee to be continuing education. (Participant Two)

Perhaps because of this abundance, four participants also described the difficulty of both finding and keeping up with accurate data. They noted that using a search engine like Google casts a wide net that gathers both reliable and unreliable sources indiscriminately. They specifically cited websites like Scarleteen and Go Ask Alice as resources they trusted.

Participants also described the challenge of staying up-to-date as new research about sexual health and clinical practice emerges daily. One participant – after noting that a quarter of their clients identify as transgender – stated that some questions remain without clear answers: “A lot of the questions that clients ask me, because I work with more subculture kinds of populations, it’s just like, ‘I don’t know. That research hasn’t been done yet’” (Participant Six).

Clinical experience. Ten of the 12 participants cited clinical experience as a factor that increased their perceived sexual intervention self-efficacy. Clinical experience, here, includes social work practice before, during, and after participants earned their MSW degrees. Participants used terms like “practice,” “time and experience,” “actually doing the work,” and “getting your feet wet and learning you can swim” to describe the process of learning from
clinical experience. Many of the professional experiences they described took place in settings not specifically focused on sex therapy, such as LGBT health centers, rape crisis centers, in-home therapy, and child protective services.

Four participants noted the importance, in particular, of seeking clinical experience outside of their comfort zone. As one participant stated,

You will see the things you’re drawn to and what you’re good at, but those are not the things that you need to be practicing…. You know, decide, ‘What are the things that I know I’m avoiding?’ And take those cases. And get really good supervision and require that of yourself. (Participant One)

**Receiving supervision and consultation.** Ten of the 12 participants cited receiving supervision and consultation as a factor in increasing their perceived sexual intervention self-efficacy. This includes both individual and group supervision with a formal supervisor, as well as peer consultation with colleagues. Participants described a variety of formats for supervision and consultation, which ranged in frequency (from weekly to monthly), membership (all sex therapists to no other sex therapists), and cost (provided by employer or paid out-of-pocket). Some participants noted that supervision and consultation can be especially important for clinicians working in private practice, which has the potential to be isolating. As part of the requirements for sex therapist certification, AASECT requires clinicians to complete 50 hours of supervision with an AASECT-certified sex therapy supervisor (“AASECT Requirements,” n.d.). One participant – who is already certified as a sex therapist by AASECT and continues to pay out-of-pocket for individual supervision – shared,
A good supervisor – a trained supervisor that you’re willing to be vulnerable with – for me has been the most essential place to work on myself and to be good and, kind of, take control of what I’m doing and build my confidence. (Participant Eight)

**Sexuality Attitude Reassessment (SAR) training.** Eight of the 12 participants cited the significance of AASECT’s Sexuality Attitude Reassessment (SAR) training. AASECT requires clinicians to complete a minimum of ten hours of SAR training in order to be certified as a sex therapist. AASECT’s website describes SAR training as a “structured group experience consisting of a process-oriented exploration of the applicant’s own feelings, attitudes, values, and beliefs regarding human sexuality and sexual behavior” (“AASECT Requirements,” n.d.). Participants described attending SAR trainings at academic programs, conferences, and workshops. Their training activities primarily consisted of listening to guest speakers talk about personal experiences and viewing sexually explicit material like films or photographs. One participant said this about the trainings’ impact: “It really desensitizes you to the quote unquote [sic] ‘shock value’ of certain aspects of the sexual world and things that people come in here with” (Participant Seven). Another participant, who continues to attend SAR trainings regularly despite having earned AASECT’s sex therapist certification, stated,

> What you’re exposed to in the SARs is always different. You know, it’s about pedophilia or needle play or anything – safer kink practices. So there’s always – going to many of them is not like the same thing over and over again. What’s the same is the idea that you’re exposing yourself and processing. (Participant Three)

**Stance of Openness.**

**Willingness to be uncertain and transparent with clients.** Ten of the 12 participants described a willingness to be uncertain and transparent with clients. Several participants
identified this as embracing a perspective of “not knowing” or “not being the expert.” Rather than identifying themselves as experts, these participants spoke of being “partners on a journey” with clients and “figuring it out together.” Some participants noted that this perspective came after a number of years during which, as less experienced clinicians, they had felt a pressure to have all the answers for clients. Transparency with clients was discussed in terms of being upfront about the limits of one’s knowledge. For example, “to be able to say, ‘Wow, that is a really great question. I will find out the answer to that and we will figure this out and we’ll work through this’” (Participant One). Participants also mentioned encouraging their clients to let them know when they felt misinterpreted, judged, or otherwise not attuned to by the clinician. Overall, participants described both being willing to make mistakes and being willing to be called out on them.

**Constant examination of own biases.** Nine of the 12 participants noted the importance of engaging in an ongoing process of self-reflection about their own biases regarding sexuality. They described an intention to remain attuned to their internal “knee-jerk reactions” and “physiological responses” that arose during sessions with clients; to make a mental note of these responses while continuing to hold space therapeutically; and then to take time later to be curious about and process those reactions. One participant concluded, “I really am committed to being brutally honest with myself….. To catch myself over and over again” (Participant 7).

Another participant noted the importance of making clinical judgments based on evidence-based practice, sexual health information, and the context of clients’ lives, rather than on the clinicians’ personal values and experience. This participant stated,

If you’re using yourself as the norm, your whole thing is becoming a mess already….

You know, it’s like, “Why am I thinking about my life when I’m talking to this other
person about their kind of journey and their lived experience, which has nothing to do with me?” So that’s the moment I kind of catch myself. (Participant Five)

*Embracing sexual diversity and clients’ values.* Five of the 12 participants discussed their recognition of the diversity of sexual practices and experiences that clients present with, as well as their commitment to focusing on clients’ values and self-determination. They spoke about practicing from sex positivity and acceptance frameworks. One participant summed up a sentiment that was common among participants: “in my head, if it’s safe and consensual, it’s fair game” (Participant 11). While participants shared that some clients’ sexual desires feel more personally challenging than others – bestiality, which is sexual activity between humans and animals, was a challenge mentioned repeatedly – they emphasized that their work is guided by clients’ self-determination. As one participant concluded,

So that’s a little bit more challenging. But it’s still like, “Nope, that is your framework. Those are your values.” I’ll tweak around the edges to make things as healthy as I can, but ultimately at the end of the day, I’m not here to tell you how to believe. Ever. On anything. And I feel like that’s really the place that therapists are called to hold.

(Participant 6)

At the same time, three participants described how their clinical ethics supersede clients’ self-determination at times. Social workers and other mental health professions are legally mandated reporters. One participant noted how this requirement and other ethical guidelines are outlined in the paperwork that clients are required to complete before beginning treatment. As this participant asserted, “The consent stuff I have to report. So if it’s with children, I have to report it. No matter what…. If it’s not consensual, if you’re harming anyone, I will report” (Participant 11).
Majority of Participants’ MSW Programs did not Prepare Them to Treat Sexual Concerns

Participants were asked whether they believed that their MSW programs adequately prepared them to treat adult clients’ sexual issues. None of the participants replied to this question with an unqualified “yes.” Nine of the 12 participants stated that their MSW program did not adequately prepare them. Two participants stated that their program had prepared them, but only because they had attended a university that offered a dual degree and earned a MSW in combination with a degree in human sexuality. One participant replied “in some ways yes and in some ways no,” depending on which sexual issues the question refers to (Participant 10). This participant had taken two classes that discussed sexuality – a human development class and a class on psychotherapy for LGBT clients – but stated that most classes did not bring up the topic. In addition, two participants expressed doubt that MSW programs would ever be able to prepare students to treat clients’ sexual issues because the programs are structured to be generalist and relatively short-term, with an average duration of two years. As one participant concluded, “The MSW program I think is about getting clinical education, but it’s a beginning, not an end…. It’s just a generalized program that teaches us to be comfortable enough to be clinicians and then open to learning” (Participant Two).

Participants’ Suggestions for MSW Programs

Participants were asked three questions intended to elicit suggestions for how MSW programs might increase students’ perceived sexual intervention self-efficacy. Participants’ responses revealed the following key themes: (a) increase discussion about human sexuality; (b) focus on teaching about the intersections of sexual diversity, culture, and identity; and (c) give students tools to provide basic sexuality education.
Increase discussion about human sexuality. Participants were asked for their general suggestions about how MSW programs might increase students’ perceived sexual intervention self-efficacy. Their responses reveal a theme of increasing discussion about human sexuality overall. One participant summed up the importance of this overarching objective for social work curricula:

When I think about a master’s program – it’s like, what level of information does a general therapist need to know? Do you know enough about the subject to ask the right question to know whether this is something that really needs to be addressed or not? And do you know the subject matter well enough to know if it’s past your capabilities? To my mind, that is really crucial in terms of creating a therapist who can practice ethically.

(Participant 6)

Participants’ specific ideas about ways to meet this objective are detailed below.

Offer a human sexuality course. Seven of the 12 participants suggested that MSW programs offer at least one course on human sexuality – four of these participants suggested that this be an elective course; three suggested it be mandatory. One participant envisioned such a course as follows:

I think an Intro to Sexuality would be good. To be able to – for clinicians or future clinicians – just to gain comfort with talking. And that intro would definitely include taking a sexual history, things like that – and comfortable [sic] about your own sexuality, knowledgeable about your own biases, and your own sexual scripts that you’ve been brought up with. (Participant 11)

Integrate sexuality education into existing courses. Six of the 12 participants suggested that MSW programs integrate discussions about human sexuality into general courses already
being taught, such as child development, couples therapy, and diversity courses. As one participant described, “integrating the biopsychosocial aspects of sexuality into general classes where appropriate” (Participant 6).

**Teach assessment skills.** Four of the 12 participants suggested that MSW programs teach students how to conduct a sexual health assessment. Participants used varying terms to describe such an assessment, including “sexual history” and “sexual status exam.” They cited the importance of practicing these skills before trying to employ them with actual clients. One participant stated, “I think even if I had just role-played a sexual status exam with a classmate, I would have been more comfortable the first time I ever broached it with a client” (Participant 6). Another participant noted that such practice has the potential to increase both clinicians’ and clients’ comfort with discussing sexual concerns:

[If it became] a standard thing you’re asking, ‘Are you sexual? If you are …’ – just whatever. Then people’s level of comfort would be in a better place and that in turn would make clients more likely to bring stuff up, if there are issues. (Participant 9)

**Focus on faculty.** Four of the 12 participants suggested that MSW programs focus on training current faculty or hiring new faculty. For training, participants described the need to increase faculty members’ awareness of human sexuality’s relevance to social work practice, comfort with sexuality topics, and ability to integrate this information into their teaching. For hiring, participants suggested seeking faculty who work as sex therapists, educators, and researchers. One participant concluded,

Whenever you’re trying to create change, it would have to be having more information available at the top, and then training faculty, and then having [sic] faculty. It doesn’t
have to be insane, but I would say it would be like full department change. (Participant 8).

**Focus on sexual joy.** Four of the 12 participants suggested that discussion of sexual risks be balanced with discussion of sexual joys. They noted that social work training about human sexuality is often restricted to discussion of sexual abuse and trauma, and that human sexuality education in the United States tends to focus on the risks of sexually transmitted infections and unwanted pregnancy. In contrast, participants cited the importance of discussing “sex positivity,” “sexual pleasure,” and “healthy sexuality” to provide a broader view of human sexuality. As one participant asserted,

> I think we need to talk about reproductive health, but talk about more than reproductive health – we never talk about sexual joy…. You know, what’s the other side of sexuality? Other than trauma, negativity, unwanted pregnancy, HIV – what’s the joy? We never talk about that. (Participant Two)

**Focus on teaching about the intersections of sexual diversity, culture, and identity.** Participants were asked what they would choose as the top three human sexuality topics for MSW programs to teach. For sake of convenience and comparison, topics suggested by participants were coded according to content areas identified by AASECT, which provides national certification for sex therapists. In order to be certified, AASECT requires clinicians to complete a minimum of 90 hours of academic coursework in sexuality education covering 17 topics, which the association identifies as Core Knowledge Areas (“AASECT Requirements,” n.d.).

These were the three topics most frequently cited by participants:
1. “Diversities in sexual expression and lifestyles, including, but not limited to polyamory, swinging, BDSM and tantra” (cited by eight participants).

2. “Socio-cultural, familial factors (e.g. ethnicity, culture, religion, spirituality, socioeconomic status, family values), in relation to sexual values and behaviors” (cited by seven participants).

3. “Issues related to sexual orientation and/or gender identity: heterosexuality, issues and themes impacting lesbian, gay, bisexual, pansexual, asexual people; gender identity and expression” (cited by five participants) (“AASECT Requirements,” n.d.).

As one participant summed up: “I feel like the complexity and spectrum of gender is a really big topic. Teaching therapists how to normalize sex and sexuality across a broad spectrum is very important. And the intersections of culture and shame” (Participant 10).

The remaining topics cited included: “Developmental sexuality from a bio-psycho-social perspective across the life course” (four participants); “Range of sexual functioning and behavior, from optimal to problematic, including, but not limited to, common issues such as: desire discrepancy, lack of desire, difficulty achieving or maintaining arousal, sexual pain, penetration problems and difficulty with orgasm” (three participants); “Intimacy skills (e.g. social, emotional, sexual), intimate relationships, interpersonal relationships and family dynamics” (three participants); “Sexual and reproductive anatomy/physiology” (two participants); and “Health/medical factors that may influence sexuality, including, but not limited to, illness, disability, drugs, mental health, conception, pregnancy, childbirth and pregnancy termination, contraception, fertility, HIV/AIDS, sexually transmitted infections, sexual trauma, injury and safer sex practices” (one participant) (“AASECT Requirements,” n.d.).
Give students tools to provide basic sexuality education to clients. Participants were asked what theories of frameworks they found most useful in treating adult clients’ sexual issues. In response, all participants cited at least three theories. Five participants cited five or more theories. The theories or frameworks that participants cited most frequently included: cognitive behavioral (six participants); psychodynamic (three participants); family systems (three participants); attachment (three participants); narrative (three participants); feminist (three participants); and The Gottman Method (three participants). Rather than indicate the utility of one approach over another, this finding highlights the multiplicity of theoretical perspectives that participants employ in their practice. One participant’s statement reflects a common sentiment shared: “It really depends on the situation – the client who’s in front of me, what’s happening. So I think I’m more eclectic and I really like to be integrative” (Participant Five).

More importantly, five of the 12 participants mentioned the usefulness of providing clients with basic sexuality education. Two participants specifically mentioned the PLISSIT model, which involves the following sequence: Permission (P), Limited Information (LI), Specific Suggestions (SS), and Intensive Therapy (IT). According to one participant,

I’ve found that so much of the work that I do falls under permission-giving and limited information and maybe some specific suggestions about where to go. I’m always amazed at how the work is so much about permission-giving and working through why a person is struggling with the fact that they’re attracted to this or that. (Participant Four)

Lack of Diversity and Access in Sex Therapy Field

Though no direct questions were asked about it, a repeated theme that emerged from the interviews was a lack of diversity and accessibility – both for clients and clinicians – in the sex therapy field.
Three participants noted a lack of racial, ethnic, and class diversity among sex therapists. One participant stated, “There’s [sic] not a lot of ethnic minority therapists” (Participant Five). Another asserted,

Most sex therapists are middle, upper-middle class. It’s not insurance-based, it’s all private pay, and they’re charging like $350 an hour. So they come to conferences and they’re laden down with Gucci blah blah blah [sic]. And I’m always like, ‘You don’t work at a clinic.’ Because the population of sex therapists is very class-based I think. (Participant 12)

Two participants described the time and money required to complete sex therapy training as barriers for clinicians entering the field. According to one participant,

In terms of an accessibility thing, any sex certification takes a very long time and it’s really pricey so a lot of people going into social work or a lot of people who want to do this work may not even be able to afford some of the resources that I was privileged to have. So finding ways of getting information out on a more general level to people who may not be able to afford to do a year long program or a two year long program and then pay anywhere from $50 to $200 an hour for supervision and that sort of thing. (Participant 10)

Three participants also noted that sex therapy can be cost-prohibitive to potential clients. As one participant shared,

A challenge that I find … is that not everybody has access to this kind of work. And many people want to do this work, are ready to work through sexual trauma or childhood sexual abuse or rape, and they don’t always have the means to do it. So I would say like finances and poverty. (Participant Four)
Finally, three participants expressed a desire for MSW programs to increase basic education about human sexuality so that clinicians might more competently address clients’ sexual concerns without needing to pursue advanced sex therapy training. As one stated, “What I would like to see is more discussions of sexuality in general education programs so that you don’t necessarily have to have the schmancy [sic] and expensive sex therapy training to do good work” (Participant 10).

**Demographics of Sample**

At the end of each interview, all 12 participants consented to answering demographic questions. While this demographic information is categorized and presented below, it is important to note that nearly half of the participants (five of the 12) expressed difficulty deciding what answers to give or noted that the labels they chose do not fully fit their experience. Examples of their responses are listed below, with references to participants’ identification numbers removed to increase confidentiality:

- “Which label do I want to give you this time? I’m literally still figuring it out for myself. So probably bisexual.”
- “Hmm, I guess I call myself … I don’t know. I don’t like any of the terms. But I guess a trans man. Because I don’t feel like a man and I definitely want to honor my trans identity.”
- “There’re so many different words I could use. I’m going to say … Mexican? You know, I’m Latina. I don’t like the word Hispanic. I could say Latina but it doesn’t say who I am or what my ethnicity is. I’m Mexican.”
• “I always say I am the human race, because race is an unscientific concept that’s problematic in deep ways. But when I have to fill something out on a computer - say to get to the next page – I’ll put in White. But I resent that.”

Participants ranged from 30 to 60 years old. Eleven participants identified as “White” or “Caucasian” and one as “Mexican.” Ten participants identified as “female,” “cis female,” or “cisgender female;” one as “a trans man”; and one as “male.” For sexual orientation, three participants identified as “heterosexual” or “straight;” three as “queer;” three as “bisexual;” one as “pansexual;” one as “gay;” and one as “an opportunist.”

Regarding religious or spiritual affiliations, three participants noted two or more affiliations. Four participants identified as “spiritual” without particular denominations. Four participants identified as Jewish – one of these as a “practicing, religious Jew” and the other three as “secular” or not practicing. Two participants identified as interested in or “leaning toward” Buddhism. Two participants identified as “Wiccan” or “witch.” Two participants stated they had no religious or spiritual affiliations. One participant identified as “Unitarian Universalist.” One participant identified as “agnostic.”

Additionally, six participants were located in Massachusetts where the researcher resides. The remaining six were located throughout the United States. Four participants were interviewed in person, all of whom were located in Massachusetts. The rest of the interviews took place via phone, Skype, or FaceTime.

All of the participants had earned MSW degrees. Two participants had also earned master’s degrees in additional fields. Five participants had earned doctoral degrees. In addition, eight of the 12 participants had earned academic degrees or certificates in human sexuality following their MSW. Of these eight participants, four had attended Widener University’s
Center for Human Sexuality Studies (Chester, PA), two had attended the Institute for Advanced Study of Human Sexuality (San Francisco, CA), and two had attended the University of Michigan School of Social Work’s Sexual Health Certificate Program (Ann Arbor, MI). Eight participants had been certified as sex therapists by AASECT.

Participants were also asked to identify their current primary professional role, the number of years they had been practicing sex therapy, and the number of adult clients they had treated in the last 12 months for sexual issues. Eleven participants identified private practice as their primary professional role. Determining the number of years practicing sex therapy and the number of clients treated for sexual issues proved more difficult to answer. This may be because there is a lack of clarity in the field about when therapy becomes sex therapy. For example, one participant stated, “Officially, according to AASECT, since January 2017. Unofficially – where I just feel like I’ve incorporated sexuality into my therapeutic practice – would be since when I graduated” (Participant Eight). Similarly, another participant noted, “So I was doing that then [during internships], but I wasn’t being supervised by a sex therapist, so I wouldn’t say that was necessarily sex therapy. It was just sexuality-related therapy” (Participant Three). Overall, participants’ answers for years practicing ranged from 1.5 to 21 years. Number of clients treated for sexual issues in the past 12 months ranged from 15 to 100 clients.

Summary

This chapter presented major findings from 12 interviews with licensed clinical social workers who practice sex therapy. The following chapter will discuss the implications of those findings, address strengths and limitations of this study, and offer suggestions for future research.
CHAPTER V

Discussion

This study had two objectives. One, to learn what factors have aided sex therapists in increasing their perceived sexual intervention self-efficacy with adult clients. Two, to identify their suggestions for how Master’s of Social Work (MSW) programs might increase their students’ perceived sexual intervention self-efficacy.

This chapter begins with a summary of major findings and their relationship to previous research. Next, limitations of the study are addressed. Finally, implications for social work practice and education are discussed, as well as recommendations for future research.

Key Findings

Training and a stance of openness increased participants’ perceived sexual intervention self-efficacy. Regarding training, this study found that continuing education, clinical experience, receiving supervision and consultation, and Sexuality Attitude Reassessment (SAR) training are factors that increased participants’ perceived sexual intervention self-efficacy. These factors are consistent with previous research that has found positive performance feedback in supervision leads to increased self-efficacy for counselor trainees (Daniels & Larson, 2001) and that as marriage and family therapists’ sexuality education and supervision experience increase, they initiate more sexuality-related discussions with clients (Harris & Hays, 2008). Miller and Byers (2012) also found that psychologists’ graduate-level and post-internship training led to increased ability to relay accurate information about sexual issues and to utilize sex therapy techniques, but did not necessarily increase psychologists’ personal comfort
discussing sexual issues or their ability to recognize and decrease biases. Miller and Byers (2012) conclude, “training that focuses on having clinicians recognize and respect different sexual views, explore their own sexual attitudes, and role-play responding to topics that are uncomfortable for them may have the most impact on this form of self-efficacy” (p. 1049). The Sexuality Attitude Reassessment (SAR) training cited by two-thirds of the participants in this study seems designed precisely for this purpose (Sitron & Dyson, 2009).

Regarding a stance of openness, this study found that willingness to be uncertain and transparent with clients, constant examination of their own biases, and embracing sexual diversity and their clients’ values increased participants’ perceived sexual intervention self-efficacy. While these themes are not reflected in the literature previously reviewed, they are consistent with Williams, Prior, & Wegner’s (2013) definition of a sex-positive approach: “A sex-positive approach means being open, communicative, and accepting of individuals’ differences related to sexuality and sexual behavior” (p. 273).

Participants’ MSW programs did not prepare them to treat adult clients’ sexual concerns. A majority of the participants in this study reported that their MSW programs did not prepare them to treat adult clients’ sexual concerns. This finding is consistent with previous research on a lack of academic training about human sexuality for both social workers (Laverman & Skiba, 2012; Merritt, 2011; Schaub, Willis, & Dunk-West, 2017) and other mental health professionals (Asher, 2007; Dermer & Bachenberg, 2015; Reissing & Di Giulio, 2010; Sloane, 2014).

Participants’ suggestions for how MSW programs might increase students’ perceived sexual intervention self-efficacy. Participants suggested that MSW programs increase discussion about human sexuality through the following avenues: offer a human
sexuality course; integrate sexuality education into general courses; teach students how to conduct sexual health assessments; focus on training and hiring faculty; and balance discussion of sexual risks with discussion of sexual joys. In addition, participants highlighted the importance of teaching students about the intersections of sexual diversity, culture, and identity, as well giving them tools to provide basic sexuality education to clients. These suggestions echo recommendations made in previous research (Riessing & Di Giulio, 2010; Risen, 1995; Rowntree, 2014; Sloane, 2014; Timm, 2009).

Lack of diversity and access in the sex therapy field. Participants raised the following concerns: a lack of racial, ethnic, and class diversity among sex therapists; time and money as barriers to entry in the field for potential sex therapists; and the high cost of sex therapy services for clients. While published demographic data is unavailable about either sex therapists in the United States or the membership bodies of professional sexology organizations like AASECT, a lack of racial and socioeconomic diversity is evident in other mental health fields in the United States. A 2011 survey by the American Association for Marriage and Family Therapy found that 70% of their clinical members report earning over $50,000 per year, 49% are primarily employed in private practice, and only 9% identify as a person of color (Todd & Holden, 2012). A 2002 survey by the National Association of Social Workers found that only 13% identified as a person of color (NASW, 2003). In addition, only 16% of psychologists identified as a person of color in 2013 (American Psychological Association, 2015). Furthermore, Laureano (2012), a co-founder of the Women of Color Sexual Health Network (WoCSHN), wrote in “An Open Letter to White People in the Sexuality/Sexology Field,”

Have you noted the lack of people of Color in the field? When I’ve brought this to the attention of some of you, your responses have mostly fallen into the category of: “the
field is what it is.” This response is problematic on numerous levels. It ignores and erases the people of Color who were a part of the field, helped create it in the U.S., those of us here today, and those of us to come. This response does not question the colonial legacies and white supremacy of which the U.S. field was created and remains (Laureano, 2012).

While no published data is available on the demographics of clients who use sex therapy services, Watter (2012) notes that health insurance companies in the United States rarely cover the treatment of sexual issues or couples therapy. Additionally, Cummings, Wen, Ko, and Druss (2013) report that while Medicaid is the largest payer of mental health care in the United States, more than one-third of counties lack outpatient mental health facilities that accept Medicaid, and communities with a large percentage of residents who are Black, Latino, or living in rural areas are more likely to lack these facilities.

Limitations of the Study

The small number of participants interviewed and the homogeneity of the sample are two clear limitations of this study. In addition, this research included only clinical social workers. Interviews with a more diverse sample or the inclusion of other mental health professionals may have yielded different results. Overall, this study’s findings are not transferable to another population or context. Furthermore, because interviews were face-to-face, participants may have been less likely to respond honestly than if the study had been conducted anonymously. Similar to other retrospective studies, this study relied on clinicians’ memories, which may not provide an accurate measure of actual experience (Miller & Byers, 2012). Finally, due to time limitations, this study did not include member checks with participants, which could have increased the confirmability of the data and the interpretations made by this researcher.
Implications for Social Work Practice

This study’s findings suggest that sexual intervention self-efficacy beliefs are not inherent traits, but can be developed through intentional action. Social workers interested in increasing their perceived sexual intervention self-efficacy might then pursue opportunities to engage in continuing education, work with clients for whom sexual concerns are a presenting issue, and seek supervision and peer consultation regarding this work. AASECT’s website also lists frequent, nationwide opportunities to participate in Sexuality Attitude Reassessment (SAR) training, though the time and financial resources required are still likely to be a barrier for many interested clinicians. SAR trainings often span multiple days and require a registration fee of several hundred dollars.

That said, cultivating a stance of openness may be just as effective as formal clinical training when it comes to increasing social workers’ sexual intervention self-efficacy beliefs. While training can provide a supportive environment in which to develop these skills, social workers may also make a personal commitment to practice a willingness to be uncertain and transparent with clients when addressing clients’ sexual concerns, to examine their own biases, and to embrace sexual diversity and their clients’ values regarding sexuality. Such commitments could be pursued without requiring many external resources and drawing instead on internal resources.

Implications for Social Work Education

This study’s findings highlight the need for MSW programs to better prepare their students’ to address adult clients’ sexual concerns. Furthermore, many of the suggestions offered by participants seem to require little in the way of financial investment by academic institutions. For example, integrating sexuality education into general courses, teaching students
how to conduct sexual health assessments, training faculty about the importance of human sexuality to social work practice and policy, and balancing discussion of sexual risks with discussion of sexual joys could all be made possible within the current curricula being offered by MSW programs. The remaining suggestions – offering human sexuality courses and hiring experienced faculty to teach those courses – would likely require financial resources. However, more than resources, the suggestions offered by this study’s participants would require a shift in perspective, for academic institutions to value academic scholarship on human sexuality in social work education.

In addition, this study’s participants raised concerns that sex therapy services have primarily been offered by White clinicians from middle- and upper-class backgrounds and within private practice settings. The lack of clinicians of color and those from poor or working-class backgrounds – as well as the high cost and limited availability of sex therapy services – likely deters many people who might benefit from these services. Likewise, the high cost and extensive time required to be trained and certified as a sex therapist may keep clinicians from more diverse sociocultural backgrounds from pursuing sex therapy training and certification. All of these factors support the conclusion of some of this study’s participants that if MSW programs focused on increasing the sexual intervention self-efficacy beliefs of their students, there might be a more expansive and diverse body of clinicians who are comfortable and confident in addressing clients’ sexual concerns, therefore increasing access to these services.

**Recommendations for Future Research**

This exploratory study highlights the need for future research on the following: (a) the barriers that prevent MSW programs from offering more comprehensive sexuality education; (b) the intersection between religious beliefs and clinical training about human sexuality; (c) the
demographics of the sex therapy field’s clinicians and clients; and (d) research that centers the voices of clients with sexual concerns.

First, while this study yielded many suggestions from participants about how MSW programs might increase their students’ sexual intervention self-efficacy beliefs, these suggestions will not be useful if MSW programs are unwilling or unable to implement them. Previous researchers have hypothesized that lack of human sexuality education in social work programs is due to heteronormativity (Rowntree, 2014) and the taboo nature of the topic (McCave, Shepard, & Winter, 2014). One of this study’s participants concluded,

I believe that for a [MSW] program to stay relevant at this point, they're going to have to start incorporating, you know, electives and some sort of lens around sexuality. But I think that there's a real – it feels like a Pandora's Box to them... It's like, they're just very afraid of it. (Participant One)

Additional research is needed to determine what has kept social work training programs from offering human sexuality education.

Second, a potential barrier for MSW programs may be conflict between the discussion of human sexuality and the religious values of both academic institutions and individual students. As Shaub, Willis, and Dunk-West (2017) note, “The intersection between religious belief and sexuality may be an issue both for those that hold strong religious views and for those with non-normative views and relationships, warranting greater attention and exploration” (p. 442). Very few of this study’s participants identified personal affiliations with organized religions. More research is warranted into how clinicians’ religious and spiritual beliefs impact their sexual intervention self-efficacy beliefs and how they engage with human sexuality education.
Third, there is little demographic information available about the population of clinicians who offer sex therapy and the clients who utilize sex therapy. Research into the demographic profiles, as well as geographic locations, of sex therapists and their clients might allow any disparities in access to become more visible.

Finally, this study focused on the voices of clinicians. There has been little research conducted that centers the perspectives of clients who seek mental health services to address sexual concerns. Hearing directly from clients regarding their assessment of these services (or lack thereof) might enable both the sex therapy and social work fields to better meet their needs.
References

AASECT requirements for sex therapist certification. (n.d.) Retrieved from
https://www.aasect.org/aasect-requirements-sex-therapist-certification

American Psychological Association. (2015). Demographics of the U.S. psychology workforce:
Findings from the American community survey. Washington, DC: L. Lin, A. Nigrinis, P.
Christidis, & K. Stamm.

Asher, R. L. (2007). Has training in human sexuality changed over the past twenty years?: A
survey of clinical psychology, counseling psychology, and doctor of social work
programs (Doctoral dissertation). Retrieved from ProQuest. (3297140)


Archives of Sexual Behavior, 38, 1016-1027.


health care infrastructure: Implications for health care reform. JAMA Psychiatry, 70(10),
1084-1090.


efficacy and counselor anxiety. Counselor Education & Supervision, 41, 120-130.


Appendix A: Recruitment Post to AASECT Listserv

Dear AASECT community,

I'm a second-year MSW student at the Smith College School for Social Work. As part of my degree requirements, I'm conducting a study for my master's thesis. If you are a licensed social worker who practices sex therapy, I would like to invite you to participate.

Some details about my study:
- The purpose of the study is to learn what factors sex therapists believe have aided them in increasing their sexual intervention self-efficacy with adult clients, as well as what they believe MSW programs can do to increase students' sexual intervention self-efficacy.
- This is the definition I am using for "sexual intervention self-efficacy": a clinician's belief that they feel comfortable discussing sexual issues and can recognize and decrease the likelihood of personal biases interfering with treatment; that they have the ability to relay accurate information about sexual issues; and that they are confident in their knowledge of and ability to utilize sex therapy techniques.

To be eligible, participants must:
- Possess a master's degree in social work (MSW)
- Hold a valid state license to practice social work
- Have at least two years of post-MSW experience practicing direct clinical social work
- Have experience providing treatment, as the sole or primary clinician, to a minimum of three adult clients (age 18+) in the past twelve months whose presenting concerns included sexual issues
- Have completed post-MSW clinical education or training in human sexuality
- Self-identify as a sex therapist

I expect interviews to take about 45 minutes. Depending on participants' preferences, interviews can take place in person (if in or near western Massachusetts), on the phone, or by Skype. Interviews will be audio or video recorded but kept confidential. All data reported in my thesis will be presented in a manner that will not identify any individual participant. Because I am a student with limited resources, no compensation is available. Before starting any interview, I would also need participants to sign and return a consent form to me.

If you are interested in participating, please reply to this post or email me at kcorbett@smith.edu. If you know someone who may be interested in participating, please ask them to email me at kcorbett@smith.edu. Or, with their permission, I can contact the potential participant.

Thank you for your time!

Kijai Corbett
MSW Candidate
Smith College School for Social Work

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).
Appendix B: Recruitment Email to Individual Clinicians

Dear (Name),

I am a MSW student at the Smith College School for Social Work. I am conducting a study for my degree requirements and am currently looking for participants to interview. You are receiving this email because you have identified yourself as a social worker and provider of sex therapy on a public online directory of therapists. I would like to invite you to participate in my study.

Here is a short summary of my study:
I am planning to interview 12 licensed social workers who practice sex therapy. The purpose of the study is to learn what factors sex therapists believe have aided them in increasing their sexual intervention self-efficacy with adult clients and what they believe MSW programs can do to increase students’ sexual intervention self-efficacy. This research has the potential to provide insight into how other clinicians might increase their own sexual intervention self-efficacy when working with adult clients, as well as provide suggestions for social work programs interested in offering more comprehensive human sexuality training.

Participants must:
- possess a master’s degree in social work
- hold a valid state license to practice social work
- have at least two years of post-degree experience practicing direct clinical social work
- have experience providing treatment, as the sole or primary clinician, to a minimum of three adult clients (age 18+) in the past twelve months whose presenting concerns included sexual issues
- have completed post-degree clinical education or training in human sexuality
- self-identify as a sex therapist

Even if you do not meet the criteria to participate, it would be very helpful if you would forward this email to people you know who might be interested in participating.

Participants will be asked to talk about their professional experiences in an individual interview with the researcher for a maximum of one hour. Interviews may take place in person, on the phone, or by Skype depending on the preference of the participant. The interview will be audio or video recorded but kept confidential. All data reported in my thesis will be presented in a manner that will not identify any individual participant. Because I am a student with limited resources, no compensation is available.

If you are interested in participating, please feel free to reply to this email or call me at (xxx) xxx-xxxx. If you know someone who may be interested in participating, please ask them to email me at kcorbett@smith.edu. Or, with their permission, I can contact the potential participant.

Thank you for your time!

Kijai Corbett, MSW Candidate
Smith College School for Social Work

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).
Appendix C: Recruitment Post to Facebook

Dear Smithies, I'm looking for more participants to interview for my thesis.

Are you - or someone you know - a licensed social worker who practices sex therapy?

I'm conducting a qualitative study about the factors sex therapists believe have aided them in increasing their sexual intervention self-efficacy, as well as what they believe MSW programs can do to increase students' sexual intervention self-efficacy.

To be eligible, participants must:
--- have a master's degree in social work
--- hold a valid state license to practice social work
--- have at least 2 years of post-MSW experience practicing direct clinical social work
--- have experience providing treatment, as the sole or primary clinician, to a minimum of 3 adult clients (age 18+) in the past 12 months whose presenting concerns included sexual issues
--- have completed post-MSW clinical education or training in human sexuality
--- self-identify as a sex therapist

If you are interested in being interviewed - or know someone who might be - please comment here, send me a private message, or email me at kcorbett@smith.edu.

Interviews can take place in person (if in or near western Mass), by phone, or Skype.

Thanks so much!

Kijai Corbett

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee.
Appendix D: Participant Consent Form

SMITH COLLEGE

2016-2017
Consent to Participate in a Research Study
Smith College School for Social Work • Northampton, MA

Title of Study: From Social Work to Sex Therapy: Factors That Increase Sexual Intervention Self-Efficacy

Investigator(s): Kijai Corbett – kcorbett@smith.edu

Introduction
• You are being asked to be in a research study about increasing sexual intervention self-efficacy.
• You were selected as a possible participant because:
  • you possess a master’s degree in social work
  • hold a valid state license to practice social work
  • have at least two years of post-degree experience practicing direct clinical social work
  • have experience providing treatment, as the sole or primary clinician, to a minimum of three adult clients (age 18+)
    in the past twelve months whose presenting concerns included sexual issues
  • have completed post-degree clinical education or training in human sexuality
  • self-identity as a sex therapist.
• We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study
• The purpose of the study is to learn what factors sex therapists believe have aided them in increasing their sexual intervention self-efficacy with adult clients and what they believe MSW programs can do to increase students’ sexual intervention self-efficacy.
• This study is being conducted as a research requirement for my master’s in social work degree.
• Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures
• If you agree to be in this study, you will be asked to do the following things: Talk about your experience in an individual interview with the researcher for a maximum of one hour. The interview will be audio or video recorded.

Risks/Discomforts of Being in This Study
• The study is a little foreseeable risks but I will be asking you to discuss your professional practice and experiences, which could bring up feelings of discomfort. You may decline to answer any question or even end the interview early if you become distressed.

Benefits of Being in the Study
• The benefits of participation include having an opportunity to discuss an area of clinical interest and to contribute to research that may be useful to the fields of social work and sex therapy.
• This research has the potential to provide insight into how other clinicians might increase their own sexual intervention self-efficacy when working with adult clients, as well as provide suggestions for social work programs interested in providing more comprehensive human sexuality training.
Confidentiality
- Your participation will be kept confidential. We will conduct an individual interview either in-person, by phone, or via Skype. If we meet in-person, the location will be collaboratively determined and provide privacy and quiet for adequate sound recording.
- All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. We will not include any information in any report we may publish that would make it possible to identify you.

Payments/Gift
- You will not receive any financial payment for your participation.

Right to Refuse or Withdraw
- The decision to participate in this study is entirely up to you. You may refuse to answer any question or withdraw from the study at any time up to seven days after your interview is conducted without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. If you choose to withdraw, I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or phone within seven days after your interview is conducted. After that date, your information will be part of the thesis.

Right to Ask Questions and Report Concerns
- You have the right to ask questions about this research study and to have those questions answered by me before, during, or after the research. If you have any further questions about the study at any time, feel free to contact me, Kijai Corbett, at kcorbett@smith.edu or by telephone at (xxx) xxx-xxxx. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent
- Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep.

................................................................................................................................................

Name of Participant (print): ...........................................................................................................

Signature of Participant: ___________________________________________________________________ Date: ______________

Signature of Researcher(s): ___________________________________________________________________ Date: ______________

......................................................................................................................................................
Appendix E: Transcriber Confidentiality Form

2016-2017

Volunteer or Professional Transcriber’s Assurance of Research Confidentiality Form

This thesis project is firmly committed to the principle that research confidentiality must be protected and to all of the ethics, values, and practical requirements for participant protection laid down by federal guidelines and by the Smith College School for Social Work Human Subjects Review Committee. In the service of this commitment:

• All volunteer and professional transcribers for this project shall sign this assurance of confidentiality.

• A volunteer or professional transcriber should be aware that the identity of participants in research studies is confidential information, as are identifying information about participants and individual responses to questions. The organizations participating in the study, the geographical location of the study, the method of participant recruitment, the subject matter of the study, and the hypotheses being tested are also be confidential information. Specific research findings and conclusions are also usually confidential until they have been published or presented in public.

• The researcher for this project, - Kijai Corbett - shall be responsible for ensuring that all volunteer or professional transcribers handling data are instructed on procedures for keeping the data secure and maintaining all of the information in and about the study in confidence, and that that they have signed this pledge. At the end of the project, all materials shall be returned to the investigator for secure storage in accordance with federal guidelines.

PLEDGE

I hereby certify that I will maintain the confidentiality of all of the information from all studies with which I have involvement. I will not discuss, disclose, disseminate, or provide access to such information, except directly to the researcher, - Kijai Corbett - for this project. I understand that violation of this pledge is sufficient grounds for disciplinary action, including termination of professional or volunteer services with the project, and may make me subject to criminal or civil penalties. I give my personal pledge that I shall abide by this assurance of confidentiality.

__________________________________________
Signature

__________________________________________
Date

__________________________________________
Kijai Corbett

__________________________________________
Date
Appendix F: Human Subjects Review Committee Approval Letter

January 11, 2017

Kijai Corbett

Dear Kijai,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Daniel O’Donnell, Research Advisor
Appendix G: Interview Guide

Interview Guide

Definition:
For the purpose of this study, “sexual intervention self-efficacy” is defined as a clinician’s belief that they feel comfortable discussing sexual issues and can recognize and decrease the likelihood of personal biases interfering with treatment; that they have the ability to relay accurate information about sexual issues; and that they are confident in their knowledge of and ability to utilize sex therapy techniques (Miller & Byers, 2012).

Research Questions:
- What are the factors that aid sex therapists in increasing their sexual intervention self-efficacy with adult clients?
- What suggestions do sex therapists have for how MSW programs might increase students’ sexual intervention self-efficacy?

Interview Questions:
1. How did you come to practice as a sex therapist?
2. Please describe your education or training in human sexuality.
3. What has increased your personal comfort discussing sexual issues with adult clients?
4. What has increased your ability to recognize and decrease the likelihood of personal biases about sexuality interfering with the treatment you provide?
5. What has increased your ability to relay accurate information about sexual issues to adult clients?
6. What has increased your confidence in your knowledge of and ability to utilize sex therapy techniques?
7. At times, if any, that your sexual intervention self-efficacy has decreased, what have you done to recover and increase it?
8. Do you believe that your MSW program adequately prepared you to treat adult clients’ sexual issues? What factors contribute to your belief that your program did (or did not) adequately prepare you?
9. How might MSW programs increase their students’ sexual intervention self-efficacy?
10. In your experience, what are the three most important human sexuality topics for MSW programs to teach?
11. What theories or frameworks have you found most useful when treating adult clients’ sexual issues?
12. Any additional thoughts?
13. Demographic information, if not obtained previously:
   a. Age
   b. Gender identity
   c. Sexual orientation
   d. Racial/ethnic identity
   e. Religious/spiritual affiliation
   f. Type of social work license and year received
   g. Highest degree earned
   h. Other certifications earned, if any
   i. Current primary professional role
   j. Number of years practicing sex therapy
   k. Number of adult clients with sexual issues treated in the last 12 months