HUMAN SEXUALITY AND CLINICAL SOCIAL WORK

Beverlee H. Filloy

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of Doctor of Clinical Social Work.

by

Beverlee H. Filloy

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Human Sexuality and Clinical Social Work

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INSTITUTE FOR CLINICAL SOCIAL WORK

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HUMAN SEXUALITY AND CLINICAL SOCIAL WORK

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Abstract

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Beverlee H. Filloy

Research in sexuality and development of treatment approaches had wide impact in the recent past. Social and professional attitudes toward sexuality have undergone major changes; attention to sexual functioning and complaints has become commonplace in various professions. Courses in sexuality are now frequently included in professional education. Completion of such studies has become a condition of certain licensure proceedings in at least one state, attesting to the public's interest in formal preparation by professionals.

Clinical social work as a major mental health discipline and part of the field of social work shares a need to accommodate or integrate such knowledge and to respond to consumer expectation of professional expertise in sexuality. To some degree, professional schools, literature and associations have reflected this surge of interest and information. However, little is known about the extent of direct application of sexual knowledge and treatment techniques in professional practice.

A review of professional attitudes toward sexual issues, information and problems, including those specific to clinical social work, is followed by an

outline of clinical social work's history and present status as it relates to sexual information and complaints. A description of sexual development and major disorders introduces a brief discussion of sex therapies and their theoretic bases and treatment techniques, with emphasis on an eclectic approach in a clinical social work setting.

The research project derives from a specialized sample of clinical social workers which provided, beyond demographic data, information about integration of sex therapy, education or counseling into clinical practice. Specifically, the research inquires into(1) the level of awareness of treatment components in the field of sex therapy,(2) the effect of education in sexuality on the conduct of their practices,(3) the rationale by which sex therapy techniques are included or excluded in these practices,(4) the recognition and treatment of sexual complaints encountered by these social workers in their practices, and(5) the effect of legal and ethical considerations in the integration of sex therapy. Conclusions drawn include the need for further research into social work values and standards as they involve sex therapies as well as implications for the future of social work practice.

DEDICATION

To Walter Friedlander

> through whom came my first full appreciation of the requisites and meaning of scholarship, with the patience and courage for self-discipline. His enduring will to learn and everlasting heart to care have been a precious, indelible gift to me and many others.

I am forever grateful to him and his late wife, Li, for their generosity over the many years of our friendship.

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The generous contributions of Harry Greenblatt, California State Department of Rehabilitation, William Hartman and Marilyn Fithian, Center for Marital and Sexual Research, Enrico Jones, University of California, Berkeley, are deeply appreciated. Janet Vandre's kindness and clarity at various junctures of the process made a unique and invaluable contribution. Barbara Merritt's willingness to review and critique the manuscript was especially helpful.

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and understanding of the endeavor. My co-therapist, Darrel Fredrickson, deserves more than a brief mention, as does Keith Reed, based on our joint endeavors.

No words can express my regard for Stephanie Peters' truly outstanding combination of good will, good cheer and good work in assisting with the dissertation, in every phase of my doctoral studies, and in the entire conduct of my office and practice. Further, without forebearance and support from my loyal husband, Jose', this and countless other professional ventures may well have failed. I extend abiding gratitude to him and to other members of our family, whose collective skills and patience have been tried.

With deep appreciation I acknowledge the privilege granted to me by clients, colleagues, children and grandchildren who have engaged my participation in their lives; my growth and learning has been enriched by theirs.

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Sacramento, California
June, 1980

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INTRODUCTION

The impetus for this project came from the author's experience in practice, teaching, supervision and examination of clinical social work during years of shifting public and professional attitudes, combined with the impact of emerging data in sexual research and treatment. The gradual extension of the author's social work practice to include treatment of some sexual disorders, advancing assignments and responsibilities in the Society and Institute for Clinical Social Work, and participation in inter-disciplinary professional activities fostered observation of and interest in an assessment of changes and amalgamation within the field.

With the adoption of relicensure requirements to include course work in human sexuality, the author served as Chair of the Ad Hoc Joint Committee on Human Sexuality Training of the Society and Institute for Clinical Social Work. A demonstration course and teaching materials were developed for potential faculty in 1978. Out of these and attendant experiences arose this undertaking to examine the degree and perspective through which specialized sexual knowledge and therapeutic skills are rejected or integrated in practice by clinical social work colleagues.

The problem to be investigated and its significance is outlined in Chapter I. Social and professional attitudes toward sexuality have undergone noteworthy changes in the recent past following a resurgence of research and publication in the field. Attention to sexual functioning and complaints has become increasingly commonplace in various professions in the last decade.

Clinical social work as a major mental health discipline and a part of the broad field of social work shares with other professions a need to accommodate this knowledge as well as to respond to the growing consumer expectation of professional expertise in sexuality. To some degree, professional schools, literature and associations have reflected this surge of interest and information. Nonetheless, little is known about the incorporation of this knowledge into clinical social work practice, or about the profession's view as to the appropriateness of such integration. Significance lies in the potential impact of data upon decisions involving practice or education for practice and, by extension, policy and services for clients.

Clinical social work's present status as it relates to sexual information and complaints is outlined in

Chapter II, including reactions to recent licensure requirements in California. Related studies revealing social work's orientation to sexual issues are reviewed, as are assessments of current professional education and literature. In a survey of social work's unique history, factors are identified which may account for some resistance and conservatism toward direct approaches in sexual complaints. Fundamental social work values appear not to exclude treatment of sexual issues, but a lack of agreement regarding social work's theory and general sensitivity toward sexuality produce confusion and hesitancy in the field.

To afford a basis for appreciating clinical social work's need for a greater grasp of sex therapy, Chapter III summarizes complexities of psycho-social sexual development familiar to most social workers. Major sexual problems and dysfunctions are outlined preliminary to a brief sketch of sex therapies, their theoretic bases and treatment techniques. A final section of the chapter is devoted to a detailed description demonstrating integration of sex therapy procedures and techniques possible in a clinical social work practice.

Research into the present status of knowledge and application of sex therapy within a specialized sample of clinical social workers is reported in Chapter IV.

The research through a self-administered survey and case vignettes inquiries into (1) the level of awareness of treatment aspects in the field of sex therapy, (2) the effect of education in sexuality on the conduct of their practices, (3) the rationale by which sex therapy techniques are included or excluded in these practices, (4) the recognition and treatment of sexual complaints encountered by clinical social workers in their practices, and (5) the effect of legal and ethical considerations in the integration of sex therapy.

The demographic data permit extablishment of subgroups or clusters for comparison and analysis of general and case material. Uneven or minimal educational preparation for dealing with sexual issues characterizes this sample as does an ambivalent or tentative acceptance of sex therapy as a useful and proper intervention in their clinical social work practice. Pluralism in practice approaches is evident, as in the relative absence of cohesive views. Conclusions drawn in Chapter V include the need for further research into social work values and standards as they involve sex therapies as well as implications for the future of social work practice.

CHAPTER I

PROBLEM AND SIGNIFICANCE

The Problem

The problem is that the extent to which clinical social work is openly addressing sexual issues and utilizing specialized techniques in practice is unknown. Alfred Kinsey[1] identified (as did William Masters[2] later) social work as the profession having potentially the greatest involvement with sexual problems and behavior, even more than medicine. Whether many clinical social workers have availed themselves of the opportunity provided by improved knowledge in any intensive or extensive way is unclear.

Clinical social work has its roots in and is part of the more general field of social work. Social workers offer diverse services in diverse setting; further, differences in theory as to the most effective way of achieving desired goals are widespread. However, a commonly shared commitment is to view the "whole" person in his social setting. Sexuality is a major thread throughout total individual life and social interaction. One cardinal point is that social workers cannot justifiably ignore sexual issues in practice, yet this appears to occur not infrequently.

The need and potential are apparent. Harvey Gochros, an early and persistent voice, wrote nearly a decade ago of the frequent avoidance or intimidation around discussion of sexual problems in social work practice. His plea was (and is) for increased knowledge for practitioners and for wider communication by educators and authors of successful treatment:

> Our society is becoming increasingly open about sexuality, accepting of its nonreproductive functions, and tolerant of diverse means of expressing it. Yet despite these changes, many social workers perceive sexual problems as the exclusive province of the medical profession or as symptoms of less embarrassing difficulties.[3]

Recently, the profession has been criticized for its failure to "take off the sexual blinders"[4], exhorted to keep informed through continuing education[5], encouraged to revise graduate school curriculum[6], and, most immediately (in California), pressed into minimal courses as a condition of relicensure.[7] In spite of these efforts, little is known about the actual "state of the art" as reflected in practice.

In the Editor's Introduction to the special issues of Clinical Social Work Journal on Modern Sexuality, 1973, Mary L. Gottesfeld writes: "Like the subject itself, education in sexuality for professionals in mental health has been painfully shy"[8]. The authors of the studies in that special issue recognize

concerns which have been increasingly reflected throughout this decade, but with little consistency. Nor is there in the literature substance fully addressing the question of how sexual issues are concurrently dealt with in general clinical social work practice. (The most relevant surveys by Leroy Schultz,[9] Michael Len and Joel Fisher[10] will be considered at a later, more appropriate point.)

One can see sporadic evidence of a growing interest in sexuality in social work practice and educational aspects. Assessments of past social work literature suggest an overemphasis on pathology and psychoanalytic interpretations of sexual behavior rather than a more appropriate emphasis on sexual knowledge and methods useful to social work educators and practitioners.[11] Nonetheless, 1977 did see for the first time the inclusion of a thorough article on sexuality in a major source book (Encyclopedia of Social Work), and a handful of publications for social workers are emerging.[12]

Social workers have also published articles appearing in specialized journals dealing with sexual issues. A random sampling of well recognized journals in sexology suggests a wide variety of interest and professional backgrounds (medicine, psychology, nursing, education for example). Social workers are

infrequently represented and seldom as major authors, nor do they seem to be addressing social work colleagues or practice, as indicated by the fact that their choice of journal was other than those in the field of social work.

Beyond the literature, there are few, if any, indications of the extent or nature of social workers' interest and practice in this field. For example, the American Association of Sex Educators, Counselors, and Therapists (AASECT), a national organization with a recognized but voluntary certification program, in the 1978 National Register,[13] lists 990 sex educators, fifty-two of whom can be identified by academic title as having social work education, five of these in the State of California. Nationwide, AASECT lists 570 sex therapists including fifty-seven social workers (five in the State of California). Some individuals hold both certificates, so that figures cannot be totaled directly.

Certification in AASECT is not only voluntary, but the standards are exceptionally rigorous and some believe unrealistic.[14] The above figures do not therefore admit of any conclusion as to how many or how few social workers are utilizing sex therapy, and may be more expressive of other factors such as financial considerations, disinclination for voluntary

certification, or unclear designation by academic title. Further, since no license is required for the practice of sex therapy in California (or any other state), the number of social workers who include such techniques as a part of their practice cannot be determined by recourse to records of a licensing agency.

Clifford Mazer[15] found that in 1976 that a preponderance of schools of social work surveyed offered at least one course in human sexuality. From 1970 to 1978, the number of courses taught increased from three to sixty-five, with the years 1972-1974 being the period of greatest expansion. These and other indicators point to an eagerness on the part of the profession to broaden the knowledge base for social workers, to narrow one phase of the "learning gap".

Clinical social work is not alone in its professional hesitancy. In the 1920's in the Journal of the American Medical Association, Robert Dickinson, a gynecologist, issued a challenge similar to Gottesfeld's fifty years later,[16] a charge referred to by William Masters and Virginia Johnson in the preface to their first (1966) publication. Dickinson points out:

> It is not a little curious that science develops its sole timidity about the pivotal point of the physiology of sex. Perhaps this avoidance . . .

> not of the bizarre and the extreme, the abnormal and the diseased, but of the normal usages and medial standards of mankind . . . perhaps this shyness is begotten by the certainty that such study cannot be freed from the warp of personal experience, the bias of individual prejudice, and, above all, from the implication of prurience. And yet a certain measure of opprobrium would not be too great a price to pay in order to rid ourselves of many phallic fallacies.[17]

Medicine, with its traditional conservatism, was scarcely hasty in its response to changing opinion and new sexual information. A review of the status of sexological study in that profession reveals that, in 1960, only three schools in the United States had programs involving the teaching of sexuality; by 1968 thirty schools had started programs.[18] In 1978, Harold Lief stated, "It is now a rare school that has no teaching program in the field . . . ." Standard texts, he claimed, were more routinely including sections on sexuality, a parallel to social work's experience. What is less clear is the number of schools (in both social work and medicine) in which such education remains elective. Also, while the educational situation has changed, many professionals trained prior to the 60's are still practicing without the benefit of recent knowledge.

Contemporary institutionalized medicine, in some quarters, would probably prefer to claim sexuality as a medical specialty (perhaps some social workers

would agree). It has, however, been observed that, even when social taboos are overcome, the interpersonal emphasis in sex therapy is difficult for medicine to accommodate given its tradition of individual treatment. A sexual system's function in health and disease is usually the function of a partnership.

John Money and others have observed that sexology seldom exists as a specialty discipline.[20] Perhaps, broad as sexual significance is in human life, that deficiency at this stage is more positive than negative; in the absence of a single specialty no extant profession can claim an exclusive province. Not only is potential room left for interdisciplinary contributions, but integration into the various disciplines where sexual issues, as a part of life, emerge in treatment is possible. In the author's view, there is significance in the ubiquity and complexity of sexuality, and the desirability of integration within established professions.

Certainly the individual and partner function (i.e. relationship) is a concept central to social work. The effort to perceive and work with the total person in his social setting and in his relationships has been of paramount importance in the profession's theory and methods of intervention for decades. Sexual matters, although often avoided professionally,

conform to these concepts. The 60's, as the results of new sexual research and treatment data began to emerge, saw significant impact on social work and other professions. In spite of the criticism, mockery, or ostracism[21] to which some researchers and professionals were exposed, findings had a wide appeal to health professionals, satisfying basic curiousity and offering hope for improved treatment. Nonetheless, the professions were slow or uneven in their attempts to grasp the research related to sexual "enlightenment."[22]

Recognizing need for change, one can still be sympathetic. Diane Brashear acknowledges social work's slowness in incorporating research in sexuality. She indicates that beyond reluctance to deal directly with sexuality are complex issues affecting all helping professions.[23] To assess the current status of practice remains a problem.

Purpose and Significance

Candor in sexual matters, including sex education or research, had been repressed in Europe in the 18th and 19th centuries. Only within the 20th century, have political, economic, religious and social influences again combined to produce a partial acceptance of sexual functioning as a field of inquiry. With the

availability of more precise knowledge, there is increased potential for ameliorating human distress.

As advanced knowledge concerning sexuality (or any other major aspect of life) becomes available, there is a basic expectation on the part of society, however ambivalent its segments, that the professions will in some fashion accommodate that knowledge in education and practice. Additionally, with diminished restraint and hypocrisy about sexual needs, direct requests for professional help are facilitated. As with all new knowledge, such processes involve first, a decision to integrate findings into the education system and, second, an application of that education in practice; at each step an inevitable lag occurs.

The author has chosen to explore the present status of the profession of clinical social work as to the incorporation of new sexual information, knowledge and application. The major purpose of this study is to inquire into the extent to which clinical social work practitioners directly address sexual complaints on the part of their clients.

Limited consensus apparently obtains among clinical social workers as to the inclusion in their practices of direct treatment for sexual complaints on the part of their clients. Some possible explanations for this

phenomenon have been examined; others still await exploration. What is the present professional attitude toward employing sex education, counseling and therapy in practice? What educational experiences have contributed to social workers' choices in these issues? What theoretical or other constraints underlie these decisions? To what degree are social workers aware of recognized components of sex therapy or current legal requirements? Are they more or less comfortable dealing with certain groups of clients? How are sexual complaints from clients treated currently? These and other variables will be examined.

This project will contribute to an assessment of the status of the profession which, in turn, may afford one basis for evaluating future educational offerings (both within and without the Society and Institute for Clinical Social Work). It is anticipated this present work may contribute to clinical social work's ongoing determination regarding professional preparation, including treatment of sexual problems.

Additionally, in supplementing a body of literature examining some issues of sex therapy as related to principles common in social work, it may be useful in decisions for practice. Discussion includes certain of the author's views on the integration of treatment of sexual disorders into a general clinical practice.

Such opinion and information may aid others in considering the applicability in their own practices.

In the broadest sense, the project's significance is its contribution, directly or indirectly, to the acceptability of sexuality as a field of inquiry, as well as highlighting the continuing need to "bridge gaps" from knowledge to practice. Through clinical social workers, the possible import may range from the large client populations directly served, to the policies of schools, clinics, agencies and other social institutions, as they are influenced by social work staff and participants.

FOOTNOTES

CHAPTER I

[1]Alfred D. Kinsey et al., Sexual Behavior in the Human Male (New York: W. B. Saunders Co., 1948), p.387.

[2]William H. Masters, "Repairing the Conjugal Bed," Time, May 25, 1970, p. 40.

[3]Harvey L. Gochros, "Sexual Prcblems in Social Work Practice," Social Work, XVI (1971), No. 1, 3.

[4]Havey L. Gochros and LeRoy Schultz, eds., "Social Work's Sexual Blinders," Human Sexuality and Social Work (New York: Association Press, 1972) p. 85.

[5]Michael Carrera and Gary Rosenburg, "Inservice Education in Human Sexuality for Social Work Practitioners," Clinical Social Work Journal, I (1973), No. 4, 261-2.

[6]Gene Johnson, "A Study of Sex Education in the Schools of Social Work," unpublished professional project, School of Social Work, University of Washington, 1972; Dale Kunkel, "The Future of Sex: Implications for Social Work Education," Doctoral Dissertation, Tulane University, 1978; Libby A. Tanner, "Teaching a Court in Human Sexuality in a Graduate School of Social Work: Strategy and Content, "The Family Coordinator, Vol. 23 (July, 1974) No. 3.

[7]Title 16, Chapter 18, Section 1878, California Administrative Code. See Appendix A, pp. 201-203

[8]Mary L. Gottesfeld, "The Editor's Introduction," Clinical Social Work Journal, I (1973), 223. Emphasis added.

[9]LeRoy G. Schultz, "A Survey of Social Workers' Attitudes and Use of Body and Sex Psychotherapies," Clinical Social Work Journal, III (1975), No. 2, 90-99.

[10]Michael Len and Joel Fischer, "Clinicians' Attitudes Toward and Use of Four Body Contact or Sexual Techniques with Clients," The Journal of Sex Research, XIV (February, 1978), 40-49.

[11]Leigh Hallingby, "Human Sexuality in the Social Work Education Curriculum at the University of Pennsylvania." unpublished Master's Thesis, School of Social Work, University of Pennsylvania, 1972; see also Mary Valentich and James Gripton, "Teaching Human Sexuality to Social Work Students," The Family Coordinator, 24 (July, 1975) No. 3, 273-280.

[12]Harvey L. Gochros, "Human Sexuality, "The Encyclopedia of Social Work, (Washington, D. C.: National Association of Social Workers, 1977), pp. 686-696.

[13]American Association of Sex Educators, Counselors and Therapists, 1978 National Registry, (Washington, D.C.)

[14]"The AASECT Affair," Sexuality Today, II (June 18, 1979), 3.

[15]Cliff Mazer, "The Development of Social Work Education in Human Sexuality: A Historical Review," unpublished paper, presented at the November, 1978 AASECT Conference, Anaheim, California.

[16]Gottesfeld, op. cit., p. 223.

[17]William H. Masters and Virginia E. Johnson, Human Sexual Response (Boston: Little Brown and Company, 1966), Introduction, p.v. Emphasis added.

[18]Harold Leif, "Introduction to Sexuality," The Sexual Experience, Benjamin Sadock and Harold Kaplan, eds., (Baltimore: Williams and Wilkins, 1976), p. 1.

[19]Ibid.

[20]John Money, "The Development of Sexology as a Discipline," Journal of Sex Research, XII (May, 1976), 85.

[21]Arthur J. Snyder ("Medical Reaction to Sex Research," a Chicago Daily News, carried in the San Francisco Chronicle, April 23, 1966) quotes a Dr. George H. Gordon, Northwestern University: "I'm embarrassed that a member of my specialty could undertake such a project," referring to Masters and Johnson. Dr. Leslie H. Farber, Washington, D. C. psychoanalyst, was quoted as condemning the work as "scientizing sex."

[22]LeRoy G. Schultz, personal communication, April, 1980.

[23]Diane Brashear, The Social Worker as Sex Educator, Sex Information and Education Council of U. S., (New York: Human Sciences Press, 1976), p. 4.

CHAPTER II

CLINICAL SOCIAL WORK AND SEXUAL ISSUES

Current Status

In 1976, the State of California moved to require the attention of clinical social work to the aforementioned educational lag by passage of A.B. 4178, the so-called Vasconcellos Bill, making (some) education in sexuality a condition of licensure.[1] Because of the overly general language of the law, and the several governing bodies involved, administrative regulations[2] were not forthcoming until late 1978. The Board of Behaviorial Science Examiners (BBSE), the regulating body responsible for clinical social work (and certain other groups) in the State, had determined that, as a requisite for licensure, clinical social workers must submit evidence of attendance in a course in human sexuality of no less than ten hours. Such courses must have been completed after 1970 (presumably to insure benefits of recent research) and must be credited under a fairly wide variety of auspices. The content is to include "The study of physiological-psychological and social-cultural variables associated with sexual identity, sexual behavior or sexual disorders"[3]

Reaction to the legislative requirement was wide-spread in the profession. Initially encountered was

an antipathy to legislative interference, constituting, in some minds, a serious political issue. Related questions, eliciting further adverse reaction, were the desirability and effectiveness of the total notion, and certain specifics of administrative interpretation, i.e., the designated hours (too long, too short), content (too little, too much) approved auspices (too formal, too casual), and manner of course satisfaction (too stringent or too loose).

The implication of a deficit in professional preparation as well as impingement upon the individual's discretion about personal educational needs brought forth understandable resentment. Perhaps there were also those social workers who inferred a directive as to how or what they should practice. Certainly not all criticism or concerns can be dismissed as resistance. None of the above questions or suggestions is without merit, although, perhaps unrealistic or politically naive.[4]

Yet psychological resistance or hostility, while less well articulated, can be discerned and warrants some examination. Speculation as to the extent that social uneasiness (in a group/classroom setting with explicit sexual materials), or individual discomfort with sexual issues influenced the professionals' perception of this modest educational undertaking,

seems reasonable. The fact that relatively large numbers of candidates had not sought such education voluntarily speaks of a possible resistance or anxiety around sexuality.

One could similarly speculate that discomfort for some clinical social workers might be occasioned by sexual material presented by clients. Indeed, in moments of candor, various experienced, competent professionals have confided such reactions. Hidden anxiety, and its indirect expression in resistance to courses, although difficult to assess directly with sophisticated practitioners, might be viewed as confirmation of the Legislature's wisdom. It remains to be seen whether the mandated "cure" has corrected those supposed "ills." A degree of resistance/anxiety apparently varies, not necessarily directly but in some manner, with factors such as age, prior education, one's own sex or that of the person(s) with whom interaction is taking place, as well as additional complex factors.

Beyond a growing conviction that substantial segments of the profession of clinical social work do manifest discomfort or resistance with general sexual material, there is room to speculate about reactions toward sex therapy. As clarified above, course offerings in compliance of BBSE requirements do not attempt

training for therapy, but, rather, survey some aspects of treatment. Reactions to this content range from an eagerness to learn about treatment techniques, to a lack of enthusiasm, a distinct disdain, and overt hostility toward the very concept.

Some social workers do not see sex therapy as a form of psychotherapy or are genuinely puzzled as to its relationship to traditional casework or fail to see any place for sex therapy in the field of social work. Others are concerned about what they perceive as legal or ethical hazards in such procedures.

Negativism, when verbalized, is expressed in lack of interest, or disagreement with method or technique of sex therapy or failure to "fit" with the present style or nature of practice. Gochros' brisk dialogue comes to mind:

> Many social workers use a number of rationalizations to cover their basic discomfort and unwillingness to engage in this particular cluster of social problems. "Sex is just a symptom" (the medical concept of sex as just a symptom is being questioned with increasing frequency). "It's not within the area of social work competence" (but it should be--social functioning certainly includes sexual functioning). "Cases like this should be referred to physicians" (is sex only physiological?) "It's basically a religious issue" (only in part--that is subject to widely varying interpretations). "Clients really don't want to talk about it" (often true if the social worker is uncomfortable about it). "I don't know how to deal with it or talk about it" (then learn!).[5]

To comprehend fully these reactions, one must look within social work's past.

Background

Social work, given its history, may indeed be as Gottesfeld wrote, particularly "shy" of sexuality in not daring to venture beyond its conservative bases.[6] It is, on the one hand, a profession needing broad social sanction for its resources and, on the other, requiring support and approval from other professions for its status. This paper is not designed to trace the convolutions of history, but some recognition of certain major forces is necessary to comprehension of the current status apropos of sexuality.

The profession was born out of the Judeo-Christian ethic with its commitment to the value of life and charity toward others. Social work has remained dependent on its agents of religious or, by extension, secular sponsorship, including the responsibility to serve as guardian of "public" (sexual) morality, in the distribution of charity--goods or services. Identified with the disadvantaged, subservient to older professions, social work has never enjoyed high status throughout its near century of existence.

In the wake of World War I, Freudian teaching

profoundly affected the fledgling profession, in imparting theories of psychosexual development, pathology, and treatment. Social work educators and practitioners early recognized the richness, potential and utility of these concepts; many adopted these views, although not uniformly nor without misgivings.

In some ways, the development and appreciation of social work theory, already retarded by low status in this country, was actually eclipsed by dazzling Freudian revelations, largely under the aegis of medicine. Social workers, finding direction and significance in analytic theories, tended also to find confirmation for their own uncertainty and inadequacy. Some incorporated psychoanalytic aspects into ongoing social work practice; others became, in effect, hand-maidens to psychiatry, further entrenching the secondary status of social work.

During the 1920's formerly puritanical social workers became, along with others educated in the same period, somewhat freer about acknowledging sexuality as a part of life.[7] Freud's great theoretic legacy, the acceptance of the pervasive force of sexuality, was instrumental in loosening socially repressive attitudes towards sex. Yet social workers did not become any more proficient in, or willing to deal directly with, sexual complaints. Florence Haselkorn

(as recently as 1971) noted that "there is some concern among some that social work is sophisticated about psychosexual development but has little knowledge or understanding about sexual practices, feelings and attitudes . . . ."[8]

In the upheaval of the 1929-37 depression, the entire system of social welfare services was altered, with the creation of vast public programs and new auspices for alleviating widespread human need. The role of many private (voluntarily supported) agencies shifted toward the provision of largely casework services which increased allegiance to indirect, intensive, open-ended treatment. Practitioners who worked within the traditional, nongovernmental settings were seen as agents of clientele, serving usually more select populations, and frequently with less rigid policy. In closer relationships with other professions (through consultation services) or the community (through governing boards), a concomitant benefit for these social workers was high professional status.

Those social workers in public (tax-supported) agencies were more often faced with extensive programs and nonspecialized populations, still frequently ministered to by "direct" relief. While aware of and utilizing accepted psychodynamic concepts, these clinical practitioners became more convinced of the

urgency and value of social action, preventive and educational treatments. They experienced generally lower professional status and less flexibility in bureaucratic policy. Their relationships with the other professions or the solvent community tended to be more remote. Not infrequently, they were seen still as punitive agents of the community, as guardians of public morals in carrying out "social" policy and safeguarding public funds.

The contrast between prevention and intervention was not new in social work and is, moreover, ever present. Nevertheless, this division, though not as sharp as portrayed here, often has distinguished the respective orientations of public and private practice philosophies. Less evident, but also potentially influential was the groundwork laid for secondary issues which have also formed a part of the brewing ferment of recent years. For example: the relative value of direct or indirect interventions, comparison between short-term or long-term care, medical or social models, the social worker as agent of community or as advocate of client, etc., were espoused with conviction by their adherents, and each had status interests attached.

In retrospect, and in macrocosm, these views need not be oppositional nor mutually exclusive. However, they have presented short-term decisions about resources

and perspectives which promoted entrenchment or divisiveness and may still reflect some polarity between social welfare and mental health values.

The predominant Freudian influence in social work education also largely precluded appreciation of the growth and sophistication of learning, behavioral, and systems theories. Practicing social caseworkers, loyal to dynamic teachings, often ignorant of or hostile to other theories, were highly suspicious of therapies with such components. Many failed to realize that theory and work in these fields were not sudden departures nor devoid of treatment successes, nor inappropriate always for social work.

When in the 60's and early 70's the many "new" therapies exploded on the scene, the family and sexual therapies were, among many, seen merely as a "vogue," at deviance from sound casework practice, which traditional social workers had no wish to embrace. The seeds, long sown, for dissention, polarization, and change flowered.

Political, national, social, generational cleavages wrenched the larger world; all professions grappled with major shifts, and social work, like other callings, experienced internal strife. Among those differences, germane and familiar from social work's past, were

prevention vs. intervention; casework vs. social activism; individual therapy vs. family (or systems) therapy; brief intervention vs. long-term treatment; behavioral vs. psychodynamic; co-therapy vs. solo therapy; experiential vs. insightful; direct vs. indirect intervention; or cognitive vs. affective. The social work reader will recognize some of these differences as resolved, others as continuing practice issues including some common to components of sex therapy.

Today with continued internal ferment, social work struggles to maintain a role in the rapidly changing external world while, in clinical practice, it attempts to respond to those parallel events as experienced by clients. One author reflects this challenge:

> Social work is in a state of radical change. The profession faces the basic question of what is social work's role . . . . The challenges . . . of varying theoretical perspectives seem to dominate a profession that is relatively new and somewhat unstable . . . . Such issues have tended to obscure the emergence of a specific area of expertise, such as knowledge of human sexuality. This is especially true when that knowledge and . . . strategies are . . . identified with an educative focus, as opposed to a treatment strategy with which social work has had a major identification.[9]

Further complicating these troublesome changes, is the uniqueness of sexuality in society. Imbued as sex is with personal and social sensitivity, in no other area

is an individual more vulnerable to criticism. A wise professional, even though eager to give appropriate, updated services, must be alert to client needs and community standards, a difficult challenge in periods of accelerating change. Also, (s)he must take cognizance of his/her own motivation and values, and possible ramifications for those who sponsor, associate or depend upon her/him. Enough to give pause to the prudent in introducing in practice or teaching therapies directly involving sexual aspects.

The conservatism of social work in the field of sexual issues, whether due to an uncertain professional status, dependence on inherently conservative social institutions, deeply-held treatment convictions, or personal intimidation, has not made for a rapid or wholesale adoption of new theory or clinical approaches. Innovations in practice and education were not undertaken without risks, and such practices inevitably encountered detractors. Those who proceeded initially in experimentation were often those in independent practice or in those agencies with unusually flexible policy.

The place of sexual information and treatment remains uncertain in practice and curriculum, along with other major and minor issues. As changing styles, theoretic modifications, recent knowledge and shifting auspices

have been accommodated (first, as explorations or, further, as accepted elements in practice), satisfactory definition and unification of social work theory has not occurred.

Yet, clinical social work has retained certain basic social work principles, which seem to the author to incorporate much that is unifying. The client is paramount. (S)he is viewed, not in isolation, but as a social entity, with relationships in a milieu, an individual, whose needs and strengths are appreciated as a unique product of integration between internal and external forces. (S)he is seen as a totality, emotionally and intellectually; biology and culture have brought this juncture in life. Intervention will begin as the individual perceives the choices. The need for help does not deny the client the major voice in the choice of goals nor the respect and acceptance from those to whom (s)he turns. The task of the clinical social worker is to determine, in concert with the client, what, among the resources available, are likely to be acceptable, appropriate and efficacious interventions. Together they seek the optimal type, degree, extent and length of these interventions so as to foster integrity.

The client's internal dynamics, personality, cognition or "system" may be the focus; his or her

"system" as it interacts with others' personal dynamics, roles, systems, learned behavior, may be the site, as may the interaction with larger social units. In any instance, whatever the theoretic bias, the social worker's task is twofold: (1) to contribute selectively a new force, that of a client-and-worker interacting relationship or "system," while (2) to be sufficiently aware of all elements in such interventions so as to insure attention to the client's needs. This process takes for granted a responsiveness to the changing attributes of the larger world and a commitment to ongoing professional education and the inclusion of new information.

A recent study by Josephine Jackson[10] concludes that while diversity of conservatism and liberalism is evident, there is strong support for in-depth knowledge of practice and application. As a group, her respondents' values include commitment to continuing professional development and seeking solutions to social problems. With concensus in these general principles, it would appear that clinical social work can, within its values, address the manner in which social and individual sexual issues and treatment are to be accommodated utilizing current research findings. Indeed, Gordon Hamilton reminded the profession twenty years ago, "social casework incorporates both scientific knowledge and social values within its

processes."[11]

The specific status of human sexuality in graduate curricula at this stage of social work development can be assessed to a limited degree.[12] Studies have examined the lag or defects in graduate schools of social work courses in sexuality. Gene Johnson[13] and Leigh Hallingby[14] have contributed to a body of evidence demonstrating the lack of full preparation in the profession, as well as the need, and the wish for such preparation. It is speculated that continuing resistance to such graduate school courses may be accounted for by several factors: (1) sexuality is not perceived by curriculum committees as a priority issue; (2) faculty members generally have not kept up with scientific finding and societal changes in sexual behavior, and are uncomfortable with the subject; and (3) even in professional schools, sex continues to be a taboo subject.[15]

According to Mazer,[16] a plateau stage in social work education in sexuality may have already been reached after the initial response in 1972-1974; relatively few changes in courses were noted in the period 1975-1978. Reflecting the present status of the profession, most instructors surveyed identified themselves as largely self-taught, lacking formal education in sexuality. Specific treatment skills for common

sexual problems in preparation for practice were not stressed in their courses.

Leadership for social work and sexuality has generally had initial sponsorship outside the traditional social work professional or educational organizations, as for example, the convening by Sexual Information Education Council of United States, SIECUS, in 1972 of an early task force composed of prominent social workers. The Social Work Program for the Study of Sex was made possible by the National Institute of Mental Health grant and the efforts of individual social workers (Gochros and others), not by social work organizations.[17]

As also noted above, social workers have published in specialized journals of sexuality, not aimed at or read by the main social work audience. Much of what has been written <u>for</u> social workers about sexuality was not written <u>by</u> social workers, but by representatives of other disciplines.[18] Indeed, as noted above, the ambivalent interest in current research in sexuality is reflected in the scarcity of the subject in social work writings. The bulk of recent literature that does exist falls into the following categories: (1) professional education components, deficits or proposals, (2) social work practitioners' lacks, attitudes and/or preparation, (3) broad social welfare/ sexual issues, commonplace or in specialized settings;

and (4) in a few noteworthy instances, discussion of direct treatment techniques and/or training. The author was able to locate only the two studies which inquire into aspects of actual social work practice with regard to sexual issues and only one of these appeared in a social work journal.

While social work's own literature in sexuality is sparse, excellent articles by social workers appear in publications under the aegis of other mental health professions, i.e. psychiatry, psychology and some interdisciplinary sponsorships. No doubt this is as much a reflection of the status of the profession and its mixed allegiances as of the topic of sexuality itself. In proportion, social workers appear underrepresented in the disciplines participating in the various specialty organizations in journals and formal presentations, etc.

In some instances, while recognizing the social work component, others cannot manage to encompass its role. For example, a 1974 World Health Organization publication on sexuality includes social work along with medicine and nursing. In an elaborate chart showing knowledge, skills, and attitudes around six major problem areas familiar to social workers in many settings (unplanned pregnancy, pre-marital relationships, infertility, marital disharmony, venereal

disease and sexual behavior), social work, nursing and medicine are well represented.[19] However, the reference to social work in the body of the text demonstrates, at the least, a narrow realization of social work's role and competence, or "savoir faire." It follows in its entirety:

> Social workers are primarily concerned with people's total life situation, and as counselors will be confronted by problems that have an important sexual content or sexual overtones, which may seem to them shocking. It will be necessary for them to develop ease in conversation with men and women both singly and together on sexual matters, and to know to whom to refer when in difficulty.[20]

In the bibliographical section, extending over five pages, no social work literature was mentioned.[21]

Although empirical observations abound, widely differing from such a limited perspective of social work's experiences, it is extraordinarily difficult to assess the restriction or expansion in practice of techniques or modalities pertaining to sex therapy. Schultz, mentioned above, published in 1975 in a social work journal, a valuable study of social workers' approval and utilization of what he termed "Body and Sex Psychotherapies."[22] No effort was made to define the "therapies," the author understandably, deeming this to be an impossible task.

In Schultz' discussion, he observed that approval is not always related to usage, and speculated about such causal

factors as lack of training, resources, space and/or agency policy. He pointed up that clients' requests invited more usage by his respondents. Consistent with the author's experience is Schultz' comment that, aside from the professional's approval or use of such techniques,

> ...waiting for a client to request a sex therapy, while supporting our client self-determination ethic, places the burden of treatment choice on the client when he may not know of all his options nor the costs and benefits of each option.[23]

He continued, reflecting, perhaps relevant to social work's caution and conservatism:

> ...that more social workers approved the use of the newer therapies than used them may be indicative of their powerlessness in influencing agency treatment policy. Perhaps, it will be the private social work practitioners who will determine the face of the new therapies.[24]

In 1978, Len and Fischer reported a somewhat similar study. They undertook a different sample, including other professions with social work. Apparently influenced by Schultz, they stated, "It was believed that private practitioners would prove more independent and less inhibited in their use of sexual therapies than clinicians employed solely by public or philanthropic agencies, which dictate staff policies and procedures."[25]

Unfortunately, there is not sufficient uniformity in inquiries to admit direct comparison with Schultz' study. Except in one instance, the items differ from or overlap Schultz' in ways precluding direct contrast. Len and Fischer however, included an item which revealed that respondents, almost unanimously, reported that some of their clients had sexual problems. There was a relatively even division as to who initiated exploration, therapist or clients.

Among issues raised in these studies requiring further clarification is, for example, the use of trained sexual surrogate partners when employed by mental health workers. Schultz found that 49.1% of social workers approved the practice.[26] Len and Fischer, who sampled psychiatrists, psychologists, social workers, marriage and family counselors, reported that 69% favored the innovation.[27] In the latter sample no use was indicated, in Schultz' sample only 1.8%.[28] These wide discrepencies between approval and usage sharply illustrate the uncertainty about social or legal forces as well as tentativeness in professional, therapeutic or policy alternatives.

A serious issue in use of sex therapy is a fear, voiced by some social workers, of attendant sexual or emotional involvement with clients. Whether inevitable or not, acceptability of such involvements, according to

Schultz, is undergoing change; nor is such a challenge merely representative of "mavericks or fugitive practitioners."[29] Sheldon H. Kardener, in a well known study of the medical profession, refers to a core of physicians and medical students questioning seriously regarding: physician-patient involvement, "why not?"[30] In Schultz' sample, nonetheless, few (only 10.6%) social workers approved of client-therapist sexual intercourse and no more than 1.8% reported actual engagement.[31] This is markedly lower than Kardener's findings for physicians where 11% reported having engaged in erotic behavior of some sort, culminating, in 7.2% of the cases, in sexual intercourse.[32]

To the author it is significant that fears of emotional involvement are seldom, if at all, raised as retardants to other therapeutic specialties or emphasis--i.e., single parent families, child abuse, bereavement, etc. All hold potential for "involvement" (i.e., counter-transference); only with sexual treatment interventions are such major alarms sounded; thus do cultural taboos still echo and affect practice decisions.

In summation, Len and Fischer observed:

> What was revealed in (sic) a somewhat conservative and traditional stance by most mental health private practitioners in their sexual therapeutic modalities. It would be inadvisable, without more data, to render opinions as to the reasons for this orientation. There is obviously still a great need for further research in the area of sex therapy.[33]

Presumably, in context, this final sentence alludes to the need and hope for greater clarification of the basis for acceptance (or rejection) on the part of mental health practitioners of use of sexual therapeutic techniques. Schultz urged, "It is imperative for the profession to begin exploring these problems and developing forums, instruments, and mechanisms whereby the issues can be addressed and policy formulated and implemented."[34]

The present study bears kinship to these previous efforts to examine practices of clinical social workers in matters of sexual complaints by clients, and to explore general positions or beliefs about sex education, counseling and therapy.

CHAPTER II

[1]Chapter 1433 of the Statutes of California, 1976. See Appendix A, pp. 201-203.

[2]Title 16, Chapter 18, Section 1878 of the California Administrative Code. See Appendix A, pp. 202-203.

[3]Ibid.

[4]Some would have opted for a screening device permitting multi-level courses, elementary or advanced. Others were distressed that, under this system, no acknowledgment would be accorded certain past work which they saw as equivalent.

[5]Gochros and Schultz, op. cit., p. 245.

[6]Gottesfeld, op. cit., p. 223.

[7]Noteworthy is an exceptional study undertaken by Katherine Davis, a social worker, with U. S. Bureau of Social Hygiene sponsorship: Katherine Davis, Factors in the Sex Lives of 2200 Women, (New York: Harper Row, 1929).

[8]Florence Haselkorn, Casebook in Family Planning. (New York: Council on Social Work Education, 1971), p. 24.

[9]Brashear, op. cit., p. 4-5. Emphasis added.

[10]Josephine A. Jackson, "Clinical Social Work: Definition, Values, Knowledge, and Practice," unpublished Ph.D. dissertation, Institute for Clinical Social Work, Sacramento, California, 1979.

[11]Gordon Hamilton, Theory and Practice of Social Casework, (New York: University Press, 1959), p. 9.

[12]Frederick Bidgood, "Human Sexuality in the Social Work Curriculum," SIECUS Report, I (November, 1972), p. 6.

[13]Johnson, op. cit.

[14]Hallingby, op. cit.

[15]Bidgood, op. cit., p. 6.

[16]Mazer, op. cit.

[17]"SIECUS Convenes Task Force on Sexuality and Social Work," SIECUS Report, Vol. 1 (March, 1973); Dale Kunkel, ed., Sexual Issues in Social Work (University of Hawaii, Honolulu, 1979) pp. vii-viii.

[18]"About the Authors," Clinical Social Work Journal, Vol. I (Winter, 1973) No. 4, unpaginated frontispiece.

[19]World Health Organization, The Teaching of Human Sexuality in Schools for Health Professionals, Public Health Paper #57, D. R. Mace, R. H. O. Bannerman, and J. Burton, eds., pp. 38-39.

[20]Ibid., p. 16.

[21]Ibid., pp. 40-46.

[22]Schultz, op. cit., p. 90.

[23]Ibid., p. 95.

[24]Ibid., p. 96. Emphasis added.

[25]Len and Fischer, op. cit., p. 43.

[26]Schultz, op. cit., p. 94.

[27]Len and Fischer, op. cit., p. 46.

[28]Schultz, op. cit., p. 94.

[29]Ibid., p. 96.

[30]Sheldon H. Kardener, M. Fuller and N. Mensh, "A Survey of Physicians' Attitudes and Practices Regarding Erotic and Nonerotic Contact with Patients," American Journal of Psychiatry, CXXX (1973), 1077-1081.

[31]Schultz, op. cit., p. 94.

[32]Kardener, Fuller and Mensh, op. cit., p. 1079.

[33]Len and Fischer, op. cit., p. 48.

[34]Schultz, op. cit., p. 98.

CHAPTER III

SEXUALITY AND SEX THERAPY

The contention that sexual matters including sex therapy may be appropriate concerns for clinical social work requires a brief review of individual psychosexual development and the societal setting as a prelude to an examination of elements of sex therapy.

Culture's impact on the person and, conversely, the individual's influence upon his society form a crucial reciprocity. This reciprocity of interaction is an essential in human life. Homogeneity or homeostasis are fleeting prospects in all life processes. Change, differentiation, conflict are essential, as are resolution and reunion which reproduce life and the cycle of growth. Warren Gadpaille captured the essence of this process when he wrote:

> None of these developmental influences take (sic) place in isolation. Everything . . . ultimately proceeds from and involves . . . other people . . . development is an expression of interpersonal relationships.
>
> The results of developmental influences are never static. Even repetitive, self-defeating behavior that represents an early fixation is not a mere mechanical echo of the past. It achieves a new and current reality each time . . . the predictable results . . . reinforce it. It is this unending, shifting, dynamic equilibrium between the individual and his human environment that holds out the possibility of change for those crippled by earlier relationships.[1]

His reference to the possibility of change includes, of course, change brought about by professional intervention. Probably no other profession has as broad a grasp of these elements coupled with as wide an opportunity for influence as does social work. "Sexuality," writes Gochros, "is one of the most powerful experiences of man. He continues:

> It can be spiritually and emotionally fulfilling and pleasurable or it can lead to loneliness, fear, and misery. Social workers could do more to enhance the former and minimize the latter.[2]

Sexuality: Individual and Societal

Sexual identity, behavior, arousal and function in the individual emanate from complex physical and psychological processes intertwined with social and cultural influences. Sexuality is established to some degree in the fetal state when differentiation of the genital organs occurs; the potential for future function is determined by the genetic endowment of the fetus. From the moment of birth, when the announcement as to sex is given primacy above all other information, social reaction to sexuality is crucial. Infants of either sex call into play certain overt and covert patterns of response and expectation from the parents, patterns with lifelong implications. For example, little girls are more frequently spoken to and stimulated by their

parents than are baby boys; older boys are more often punished by physical means while older girls are disciplined by withdrawing affection.[3]

Psychosexual development 'post-partum' for both sexes proceeds in widely recognized developmental stages. In the infant (symbiotic) period a foundation is laid for future trust, confidence and attachment vital to all human relationships. The toddler stage deals with issues of autonomy and intimacy which derive from the separation/individuation of "psychological birth"[4] as self and object are gradually differentiated. As part of the developing self-awareness, gender identity is fixed very early, preceding the Oedipal experience.

From the Oedipal struggle the youngster emerges with further identifications, consolidations and preferences highly pertinent to sexual development. A relatively asexual period (latency) further solidifies gender and role identity with peer interaction and bonding forming a crucial component for both boys and girls.[5] A resurgence of sexual drives is experienced in adolescence. Among other major tasks of this period for the young adult is the integration of genital, reproductive capabilities with an altering body image, expanding social-sexual roles and incipient adult-sexual responsibilities. Ultimately these include a responsibility to loosen the filial bonds and

establish new ties.

Commitment to an intimate relationship, a linking of adulthood, and usual subsequent child-rearing recapitulate all of the previous life stages. In marriage, for example, the tenacity and complexity of separation/individuation issues may even surpass those of the early parent-child relationship. In child-rearing, the parent frequently experiences anew the childhood and adolescent sexual conflicts, with regression, fixation or resolution as possible outcomes.

In mid-adult life, children mature, marry and reproduce; middle-age personal expectations and new social roles demand a further integration in the (grand-) parental psychosexual scheme. Later phases of life with frank hormonal changes, diminishing physical capacities, and increased incidence of illness, necessitate formation of different body images, which, in turn, affect the expression of sexuality. Often the experience of increasing social or personal losses, especially in significant relationships, threatens to overwhelm sexual and psychological equilibrium. Indeed, Erik Erikson contends that the ultimate goal of this stage is the triumph of integrity over despair.[6]

These concentric psychosexual personal developments

take place within ever expanding social units. Initially, the mother-baby bond is the essential experience although not uniquely important. (Recent studies, in a neglected facet of child development highlight fathering as an important component in infant interaction and nurturing.)[7] Peer relationships broaden the child's capacity for attachments, and serve as essential preludes to intimate adult pair-bonding, enabling individuals to maintain extra-familial attachments and deal successfully with larger social units. Family, subgroup, community, culture, society all contribute uniquely and steadfastly to the individual's course of development. These contributions may deprive, inhibit, enhance, reward, punish, shape or misshape; they therefore influence, cumulatively, all subsequent stages.

The result for each person is a composite of psychosexual preferences, prowess, and practices which combine native propensities with acquired cumulative social learning to result in identity and character. Defense structures including emotional reactions and cognitive judgments about sexuality are individualized, as are vulnerabilities. Innate processes and predispositions, themselves highly complex, are dependent upon internal and external forces, the interplay of which produce maturation. Without the benefit of societal stimulation and demands, the infant would

not grow or survive. Without the inborn energies and unique contributions which individuals derive from psychosexual processes, society would also cease to exist.

The goal of socialization is to intervene in the individual's psychosexual development to insure ultimate (psychosexual) expression consistent with the culture and its perpetuation. The goal for the individual is to interact with his society with skill and impact sufficient to obtain gratification of his essential needs, including the kind of personal psychosexual expression which will insure his survival. In so doing, individuals affect the course of their society in evolutionary or revolutionary ways.

Societies throughout history have never been neutral about the sexuality of their members, partly because of the potential for pleasure and unification as well as for pain and conflict, and partly because of the link of sexuality with the awesome and beautiful power of reproduction. Given the delicacy and intricacy of psychosexual development, multiple opportunities for impact, disturbance and restoration in the individual occur.

Herein lies social work's unique potential. The elements of constant change in <u>both</u> the individual and

his milieu, (small wonder that individual and community perception of social-sexual values are seldom in precise synchronization) provide the opportunity for intervention by those professionals, i.e., clinical social workers, best equipped to contribute in that arena and mixture.

In contrast to that of the Victorian past, the present social stance toward sexuality is one of great frankness. Greater legitimization of sexual research, acceptance of recreational sex (not necessarily procreational), validation of female sexuality, and lessening of discriminatory biases toward alternative preferences, are becoming evident.

While the societal forces giving rise to this period of "enlightenment" are outside the purview of this discussion, they have had sufficient force to produce what has been called a sexual "revolution." In the author's view, such an extreme term is misleading, obscuring the facts that (1) many older values in this area of life are still held by a large segment of the population, and (2) no consolidation of new values has occurred, or been incorporated into the culture and (3) no accurate yardstick(s) of past attitudes exist. A majority of the population, it could be contended, still learn about sexuality more covertly than overtly. Such learning is often inaccurate and

incomplete, and fear or guilt is still largely attendant upon sexuality. Conservative values may, in truth, represent wisdom, even though hidden or distorted. Vernon Bullough, a historian, comments:

> Change comes too slowly to undo the effects of generations . . . the basis . . . should be the new models of sexual behavior drawn from the social and behavioral sciences. These new norms will not be a panacea and there is the danger that in undoing the bad . . . we might well construct the basis of a more serious future misuse.[8]

To term the current state of affairs a "revolution" in sexuality would be to describe inaccurately a process that is neither suddenly nor fundamentally altering sexual experience for most human beings. An inspection of history suggests this present phase may be only a cyclical rotation of public moods regarding sexuality rather than a revolution.

In the context of individual-society interaction, one of the regrettable consequences of the present (otherwise beneficial) sexual enlightenment is a discrepancy between social and personal expectations. Repressive elements in the recent past impinged unduly and inconsistently on personal sexual behavior, expression, and attitudes, creating a myriad of pathological consequences. Presently, an inconsistent overemphasis on sexual performance and a corollary emphasis on simplistic expertise or sophistication

have created or compounded difficulties for many. In either extreme, sexuality is regarded as less than an integral part of life, rather as a separated segment of life, to be either hidden or paraded.

Emphasis on sexual performance as accomplishment or an orgasm as "goal" frequently has negative effects on the individual and his or her relationship. Soon, perhaps, sexuality can assume its role in society with proper perspective, neither falsely concealed nor foolishly featured, but appreciated as an essential part of personhood and of relationships central to life and love.

Many professionals in the health field have responded in a timely way by acquiring new information as they themselves have become aware of the need. Workshops and continuing education courses have burgeoned; specialized literature and professional organizations have proliferated; professional schools' curricula have been revised; clinics and social agencies' services have been restructured, and new diagnostic categories have been developed. Withal, there is little consensus as to who should be treated and by whom, what causes or constitutes disorder, and what is proper care. Many practicing clinical social workers and other mental health professionals are uncertain about their own future roles or practices.

With recognized expertise and:

> . . . knowledge of normal developmental, cognitive and psychological processes of personality functioning in various context throughout cultural variation, environmental pressures, and supports. The effect of crises, frustration, deprivation, and developmental problems upon people and normative ways of coping . . . family dynamics, as well as an understanding of environmental pathology . . .[9]

clinical social work urgently needs to consider (or reconsider) the problem and potential of sexual features in treatment, direct or indirect, for its wide clientele.

Sexual Problems and Therapies

Full discussion of the etiology of sexual disturbances or complaints would involve consideration of extensive and intensive aspects in both the individual and the society. Such a broad range cannot be fully addressed in this context. Further, the present state of research, knowledge, and theory precludes conclusiveness. Many fundamental issues have scarcely been articulated; for example, the personally adaptive function of sexual pleasure which may exist apart from reproduction or bonding.[10] With only a limited knowledge of function, classification of dysfunction or disorder is difficult.

Sexual disorders fall into two broad categories: first, the organically based impairments, including congenital physiological, or anatomical defects, as well as disease or trauma-linked conditions; second, the functional (i.e. nonorganic) impairments encompassing the enormous range of psychological, cognitive and interpersonal (social) difficulties. These may range from disturbances and fixations in developmental stages (neurotic, borderline or psychotic states) to inadequate social skills or faulty learning. In most clinical observations a mixture of causal factors is noted. This paper will not deal with those disorders considered to be organically derived.

Current confusions are described in a recent study:

> At the present time there is no clear-cut, universally accepted theory of the etiology of sexual dysfunction, nor the cluster of symptoms that are pathognomic to any particular condition. Neither are there proven objective standards of behavior for what is normal, adequate or functional.[11]

Considering the same nosological issues, Kaplan editorially pleads for limiting the use of the term "sexual dysfunction" to psychophysiological disorders produced by anxiety.[12]

Those who share her views commonly see dysfunction as synonymous with anxiety occurring in one of three

phrases: desire, excitement or orgasm. However, Bernard Apfelbaum,[13] in a thought-provoking paper, questions the common premise that anxiety per se is the first order cause of dysfunction. He proposes that for the functional population, anxiety has the opposite effect, stimulating automatic functioning.

Behaviorists, such as Jack Annon, use terms such as behavioral surfeits or deficits, thus encouraging descriptive precision.[14] Still others classify sexual disorders according to which stage of the erotic process is the generative factor: from proception (courtship, solicitation) to acception (sexual engagement) and conception (reproduction), a formulation which offers a useful framework and allows contributions from the biological, psychological and sociological disciplines, while not obscuring the clinical manifestations of commonly recognized disorders.[15] Diane S. Fordney-Settlage has formulated a promising assessment including individual and (partner) unit; she argues such a scheme would aid in clarifying the focus for individual or couple therapy and the appropriateness of specific sex therapy.[16]

Desirable as it would be to rely on a single classification and treatment system, consensus would be premature. At this time, presenting symptoms are still the most usual point of reference for the male

performance, i.e., erectile difficulties, impotence, premature or retarded ejaculation; for the female, orgasmic disorders, i.e., anorgasmia, vaginismus, dispareunia. Increasing attention has been accorded "hypoarousal," in both men and women. ("Disorders of desire" is listed as a new category in the Diagnostic and Statistical Manual of Mental Disorders.) [17]

In an editorial written more than ten years ago, Albert F. Axe states:

> The pervasive processes called emotions and motives cannot be conceptualized by either physiology or psychology alone. These states are so obviously psychophysiological in nature and so important in human life that there is great pressure for application of psychophysiology to these complex problems. [18]

It would be difficult to find an area to which this statement seems more applicable than the study of sexual arousal and function.

The lack of a universal terminology complicates discussion of treatment methods for sexual complaints. The very term "sex therapy" apparently conjures up, for some clinical social workers, techniques intrinsically different from those of other problem areas. To some, the term is considered synonymous with mechanistic, simplistic procedures to which they, as social

workers, are opposed or, in which they have no confidence. Others view such therapy as an application of methods alien to their practice, e.g., co-therapy, conjoint work, or the focus on a specific symptom. "Sex therapy" is for other social workers a form of medical treatment inappropriate for non-medical therapists. Nonetheless, most social workers contend that, directly or indirectly, they afford treatment which can alleviate sexual problems. At the extremes of the continuum are those who treat sexual complaints indirectly (usually in classic psychoanalytic psychotherapy or its derivatives) and those who approach the complaint directly (with most often physical, cognitive or behavioral interventions). Between are other mixtures: those who use direct methods combined with psychoanalytic features and those who view sex therapy techniques as but one adjunct to concurrent psychotherapy.

Treatment Considerations

Historically, the Masters and Johnson's model of rapid concentrated treatment of a couple away from home by a mixed gender team became something of a standard in the field. Inadvertently, and aside from the pervasive social taboos, this model may have contributed to certain resistances. First, while by no means absent in their concepts, the psychological underpinnings for

various reasons were not highlighted in their early publications. Second, the format, with its basis in clinical research, added to the impression of mechanical treatment, in laboratory isolation, "apart" from the usual life and personal issues. Third, even though some of the specific techniques did not originate with Masters and Johnson, the team's success in combining these into a total treatment program was a seminal contributions, a contribution which was, for a time, so arresting that alternative work, with different mixtures was eclipsed or undervalued.

In the past few years, alternative, expanded adaptations and divergent theories or modes have been recognized, although gradually. Many of these move away from the "medical" model or other features associated with Masters and Johnson and lend themselves more readily to incorporation by those in service fields with different theoretic emphases.

While complex issues--theoretical, philosophical, etiological and stylistic--underlie treatment of any human problem, there is a further complication in an increasing body of experience suggesting that sexual dysfunction can exist apart from psychopathology.[19] For professionals accustomed to viewing symptoms as having meaning beyond themselves this is a difficult notion to encompass; hasty rejection of this idea may

preclude consideration or selection of appropriate intervention techniques for sexual problems by clinical social workers and other therapists.

In a rapidly changing field, no discussion can purport to be all inclusive. However, current treatment approaches fall into one or another of four rough categories: those which emphasize (1) the physical, (2) the cognitive-behavioral, (3) the psychodynamic or (4) the eclectic. All but the third category could be said to denote direct interventions. The physical approach involves medical examination and treatment affecting the sexual organs as well as treatment for chronic or other conditions which bear upon sexual function. These interventions may be surgical, pharmacological, hormonal or neurological. Additional to these treatments, (usually administered by a physician), certain physical techniques may be part of non-medical sexual therapy. For example, instruction in the Arnold Kegel[20] pubococcygeal exercises for improved vaginal tone and response often is beneficial without other intervention, as is James Seman's[21] procedure for premature ejaculation (or, as modified, the so-called "squeeze" technique). Mutual caress exercises, non-demand positioning, heightened sensual awareness, genital and sexological examination between partners, selective use of surrogate partners, and abstinence from nonprescriptive drugs illustrate the

physical approaches which have been efficacious, in and of themselves, with sexual disorders.

Cognitive approaches include education and reeducation. Traditional negative attitudes toward sex, faulty information about male and female physiology or anatomy, unrealistic marital expectations, erroneous concepts of "normality," "masculinity," or "femininity," can and do produce irrational fears and inadequacy. Cognitive therapies interpret the presenting symptoms in terms of basic misconceptions and thought patterns.[22] Learning new concepts of bodily awareness, self-image, communication skills, acquiring accurate sexual knowledge, contraceptive information, and constructive imagery can dispel difficulties and enhance pleasure. In addition, the process of shared learning may strengthen bonds among couples.

Adherents to the behavioral model, based on learning theory, hold that sexual difficulties are the result of erroneous conditioning. The therapist shapes behavior by replacing faulty with desired behavior either in the individual or in interaction between the partners. Systematic desensitization, flooding, assertive training, modeling and relaxation all may aid in the active confrontation of major issues or in a corrective emotional experience for the individual or couple and a consequent freedom from symptoms.

Since behavior therapy procedures require clear specification of the response or behavior and/or stimulus to be modified, those who advocate this approach hold that more precision and, hence, greater predictability of results are possible.[23]

The psychodynamic therapies assume that sexual dysfunction is symptomatic of intrapsychic conflict, conscious or unconscious, founded in developmental experiences and resulting in defense patterns, individual symptoms, and in interpersonal discord. Therapy conducted through historical exploration, dream, fantasy, and transference analysis allows the individual to achieve great insight and a wider scope of effectiveness. When utilized with groups, families or couples, this approach makes it possible for social interaction elements to enter and expand the range of possible interventions. There is an underlying conviction that improvement in personal or interpersonal functioning of the individual or couple will alleviate the sexual complaint indirectly.

That these approaches are not discrete is self-evident; overlap is abundantly clear. Classic Freudian psychoanalysis is also a type of learning; "didactic" therapy can be a source of insight; touch by a spouse can effect the vestigial yearning for parenting; the accepting response of the (non-behaviorist) therapist may be a "conditioner"; and almost any intervention

reverberates throughout an entire personality of family/social system (the so-called "ripple" effect) to the benefit of many.

No single approach can claim a flawless record on behalf of troubled clients; the frustration with theory is not unique to sex therapy. For, as social work and other mental health literature reflects, no single totally integrated theory of human growth, development, behavior, pathology or interaction exists, and hence no fully satisfying foundation for therapeutic endeavors is available.

Helen S. Kaplan addresses the psychoanalytic profession as follows:

> The survival of psychoanalysis depends on its accommodation to a multidetermined model of pathogenesis. Deep unconscious conflicts which derive from childhood are of course very important causes of sexual symptoms and of other disorders as well . . . . However, <u>they are not the only causes</u>. <u>More immediate anxieties and learned reactions may also produce sexual and other symptoms</u>. In addition, making conscious the previously unconscious, which is the major strategy of psychoanalysis, is an important but <u>not</u> unique way of modifying human behavior.[24]

It is not surprising, given the multiplicity of etiological factors in human response, that theoretic schools clash in this arena. While inappropriate for elaboration in this paper, it is worth noting that

other authors[25] are attempting to emphasize the complementary aspects of behavioral and dynamic theories. To quote Harry Guntrip, "It is more important to care for people than to care for ideas."[26]

Sexual functioning has its roots in biology and physiology; aspects of physical health or pathology, pleasure or pain, are elements of sexual performance. Sexual behavior, like other behavior, can be expressive of and influenced by a variety of emotional reactions, and it is subject to cognitive, psychological and intrapsychic influences. Sexual activity, as it involves other human beings, calls into play rich interpersonal components and object-relations. Sexual expression takes place in a cultural setting and has been, in some ways, learned or conditioned. No single perspective suffices in describing sexuality.

It is therefore not difficult to see why commonly used texts in the field of sexology have chapter headings or sections such as: "Biology, Behavior," "Culture" or[27] "Human Body, Human Sexual Behavior, Sex and Society,"[28] nor why William Hartman and Marilyn Fithian subtitle their treatment approach as "biopsychosocial."[29] Nor is it uncommon to encounter words such as "amalgam" or "eclectic" or "complementary" in descriptions of sex therapy by various authors. To some readers these terms imply artful incorporation, flexibility,

innovations and variations called forth by a complex task. For others, such language connotes fuzzy-headed, unrealistic thinking, or departure from and apathy toward theoretic convictions.

A majority of sex therapists, utilizing divergent primary disciplines, examining evolving theories and participating further research, would undoubtedly term themselves "eclectic." Virginia Sadock comments:

> This model . . . requires that the therapist be able to take the best of a variety of schools and apply them . . . . Accordingly, the therapist may be a participant-observer at one moment--active, forthright, open and a passive observer of the couple's interaction the next. If a psychoanalytic interpretation is called for, it is made. If, on the other hand, a didactic presentation of sexual technique or child-rearing practices is required, that is given. In practice, most experienced therapists do the same things with most patients, regardless of their particular theoretical orientations.[30]

All treatment holds a similar goal: change in some aspect of the client's life and/or the subjective experience of that life. The task for clinical social workers or other therapists, as mentioned above, is to be knowledgeable and alert enough to discern which client needs what format, to be sufficiently self-aware to suspect in her/himself an overdevotion to certain modes, to be enough of a continuous learner to consider new theory and approaches.

Each theory and method has its staunch adherents: each sees sex therapy from a different view. No definition of sex therapy will satisfy all. The author's use of the term describes a brief process of outpatient care which, either as an adjunct to other psychotherapy or as the therapy of choice, incorporates psychodynamic principles and direct treatment of sexual disorder in effecting change in the individual's or couple's symptoms.

Each of the above several approaches has been used with some success in treating individuals or couples presenting any of various sexual complaints and involving both homosexual and heterosexual orientations. For purposes of this discussion, the focus will be primarily on sex therapy for male/female units (or those heterosexual individuals lacking partners) where organic factors are not at issue. While the author has worked with individuals and couples with different problems or orientations and is aware of large special populations not among the "sexual elite,"[31] examination of related issues cannot range so broadly in this context.

Work with the female/male unit, within whatever theoretical preference, raises clinical issues closely related to those in marital counseling. Indeed, no clear-cut lines can be drawn between marital and sexual therapy since sexuality is but one of many shared parts

of life in marriage; issues of cause or effect in the complex texture of the relationship defy analysis at times. To attempt too sharp a contrast is unrealistic or unwise. Several authors (e.g., Ernest Bruni, Kaplan, Fordney-Settlage),[32] suggest the desirability of the therapist having ability in both areas.

Whatever one's conviction in that regard, some techniques in sex therapy resemble or have borrowed heavily from the marital field. The enormous literature and findings in that field cannot occupy space here, but certain relevant similarities will be identified, for example, the contrast of conjoint or individual emphasis. It is well known that Masters and Johnson, as well as others, have insisted that the couple is the unit of treatment, and that there is no such thing as an "uninvolved partner." Other therapists have explored techniques which allow the possibility of help for only one of the partners, individually or within groups. These adaptations have been in the service of the client for whom no willing partner was available, or as a measure of economy; in other instances they represent a conviction that the problem rests in the individual.

Seeing a couple in either sexual or marital therapy shifts the attention to the family system, a concept no longer novel. Hotly debated in the past, especially as marital-family therapy emerged in the early 1960's,

a growing body of successful experience with systems theory has earned the respect of many in the field. If not fully sanctioned, it is now commonplace and increasingly valued. Nonetheless, there are those who do not agree as to the merit of the systems theory or those who feel it denies the essence of psychotherapy, i.e., intrapsychic phenomenona. The notions of a family system, "balanced" or "imbalanced," of an "identified patient" as the "symptom bearer" of "family" sessions, of "structured tasks," etc., are antithetical to their convictions about the psychotherapeutic process.

The extent to which systemic concepts act as deterrents to incorporation of sex therapy by clinicians is unknown; again, the author holds the seeming dichotomy between emphasis on internal or external systems to be more apparent than real. Recent contributions from object relations theory, for example, especially the concept of projective identification in marriage, have potential for bridging the schism.

Both sex therapy and marital systems therapy frequently employ co-therapy teams. Hartman and Fithian, Masters and Johnson, two of the earliest treatment teams, both solidly support the value of male/female team and prefer to reserve their full training programs for such teams. Kaplan and others do not find it essential, rather such intervention is used selectively.[33] The co-therapy aspect

is often a point of disagreement raising complications in transference, counter-transference, modeling and empathy. One's comfort, one's relationship to the co-therapist(s), one's theoretic stance and, perhaps most significantly, one's past experience are critical. Those therapists most likely to endorse the co-therapy approach may be those whose ventures into this field were by happenstance in collaboration with a co-therapist, while those accustomed to working individually perpetuate that style. Many such variables have not been subjected to rigorous research; subtle and complex factors cannot be fully identified, although investigation is anticipated:

> There is today very little information as to why various therapy approaches are effective with specific cases. We have not yet isolated the essential vs. the sufficient variables necessary to promote sexual functioning. Nor have we isolated those techniques which produce maximal effect alone or in combination, minimal cost in terms of therapist time and patient expense, or ways in which maximal efficiency can be produced.[34]

Other technical features, departing to a degree from classical forms of psychotherapy, are fairly uniform elements in sex therapy. They are: (1) establishment of time limits in length of therapy, (2) employment of directive techniques prescribed by the therapist(s) and (3) emphasis on the experience and completion of assignments outside of the professional office.

Because of the need for cooperation and goodwill between partners, writers in the field emphasize the need to set aside other relationship issues and focus on the sexual experience once that treatment has been agreed upon. Distractions of any sort are detrimental to the emotional, sexual exploration of intimacy; hence therapy programs often have time limitations and, at times, recommendations for some change in daily routines. While there is little agreement as to what constitutes "brief" treatment, most sex therapists use that term in describing their work. Benefit, of course, can accrue to a couple by virtue of their simple agreement to provide blocks of time for each other; the effectiveness of graduated eroticism of assignments may be realized more readily with minimal time lapse between "tasks."

The role of sex therapist as teacher and, at least, temporarily, "manager" of the couple's sexual experience is at odds with much traditional psychotherapy. To instruct a client in caress or masturbation techniques, to prohibit coitus or to assume any didactic stance is to depart from the traditions of clinical social workers who seldom, if ever, would prescribe experiences outside the sessions. (Yet in earlier years, social workers would have been expected by the community to advise or even admonish clients.)

These very intimate assignments and the resistances or

other reactions they evoke, appear to be the key to success in sex therapy. The temporary dependence on the therapist alleviates some anxiety and affords permission to experience inherently pleasurable exchanges. Action is, in these instances, easily as beneficial as discussion.

As noted above, much of the therapeutic work takes place outside of office sessions. In addition to the direct interaction between client(s) and therapist, the structured experiences obtained away from the office are crucial. Joseph Lo Piccolo[35] and others have devised mechanisms to insure that tasks are not resisted or "forgotten." The couple's experiences with their assignments are often valuable diagnostically. The pattern of interpersonal friction or intrapsychic conflict are revealed and can be dealt with either in the conjoint session or deferred for subsequent or individual work. Those who complete the tasks are directly rewarded by greater self--or partner--awareness, sensual pleasure and some sense of mastery.

Other techniques and methods which are at variance from older theories or are still in dispute among sex therapists cannot be discussed here; experimentations and research remain in their infancies. Ian Alger sums up as follows:[36]

> The issue is not whether psychoanalytic theory or interpersonal theory have been invalidated, but rather that new clinical findings challenge all of us to create a broader and more accurate theory of human behavior and the factors which influence it.

To the question of who are the sex therapists, there is no single or thorough answer. Currently, no recognized professional organization nor governmental body which regulates sex therapy or sex therapists exists. Self-identified sex therapists come from a wide range of professional backgrounds, with health and social science fields predominating.

No agreement exists as to the type of specialized education or training which is desirable or essential, nor does any certainty exist about professional school curriculum or remedial education in sexuality in the involved professions. The nebulous distinction between therapy, counseling and education, also prevalent in other professional endeavors, confounds the question of preparation in the field of sexuality as well. The sex <u>therapist</u>, to the extent that (s)he sees his/her role as a psychotherapist, is presumed to have skills and techniques not only in specifically sexual treatment, but also in areas dealing with personality structure and interpersonal dynamics. The sex <u>counselor</u> role is more limited, suggesting support and advice based on sensitive perception of the client's total situation and the counselor's own sound knowledge. The sex

educator provides accurate information and corrects misinformation through a variety of methods; (s)he must be alert to the client/student's emotional set and mental capacities. These roles overlap in the clinician, each is potentially beneficial; the distinction, if it exists, appears to be in the depth of intervention in the client's life and what the extent and type of preparation for degrees of intervention should be.

Bruni,[37] among others, contends that individual psychotherapists have done and are doing the bulk of sex therapy and that they need special training whether they specialize or not, since sex therapy necessarily involves a unique category of psychotherapeutic techniques demanding skill.

Insistence as to the desirability of medical training as a requisite for sex therapy on the part of some authors fails to convince. That position does serve as a reminder that within the total field of psychotherapy consensus as to ideal preparation and qualification has never obtained; those differences cannot be herein resolved.

Bullough commends the social and behavioral model as "more valid . . . it eliminates the stigma of pathology and overcomes the problem of illness. The problem is to avoid making any model a dogma . . . . All of us

have a responsibility to develop new modalities and in the process to be tolerant of findings that are different from ours."[38] Certainly these words could be considered by clinical social workers as they examine convictions about sex therapy.

Integration of Clinical Social Work and Sex Therapy

In any general practice of clinical social work including work with individuals and couples, overt sexual complaints can be anticipated. Many social workers still prefer to treat these indirectly; some, for a variety of reasons will refer these problems to colleagues. Other social workers choose to incorporate treatment of sexual disorders within their own practice. Among this latter group diverse styles, settings and resources are represented. The following description illustrates one way, which the author asserts is a successful integration, i.e., clinical social work practice encompassing treatment of sexual disorders. This discussion is limited, as above, to heterosexual couples, recognizing the author and many social workers engage in treatment of other complaints, sexual alternatives and for different client populations.

Eclectic Approach

Clinical social workers who include sex therapy

techniques in their practice, usually evolve an eclectic approach, drawing from several theoretic bases. First, a psychoanalytic framework (expanded to include advanced concepts of a personal self and object relations) provides an orientation for understanding individual personality and interpersonal function. While not subscribing to the narrow biological base of earlier Freudian doctrine, psychosexual drives and historical development are held by these social workers to constitute a major force for each person. Implied are individual study and diagnosis. Interpersonal interactions are largely understood as extensions of the personalities involved.

The expanding fields of marital and family therapy have contributed a second source of concepts useful in sex therapy, notably through communication and systems theories. It is beyond the scope of this statement to reiterate the many considerations which govern those theoretic positions and their distinction from traditional individual psychotherapy. In sex therapy, the most commonplace contribution is demonstrated by work with a couple as a unit and the concommitant focus on clients' interaction as opposed to interaction with the therapist.

Co-therapy teams are frequently encountered in sex therapy. The premise held is that each client/partner

can benefit from contact with both male and female therapist, while having one therapist as gender model. Transference and counter-transference elements, while not often addressed directly in the therapy, are acknowledged and presumed to be minimized by this format. The value of a second professional perspective has, of course, made this mode a frequent adjunct in marital and family therapy.

Thirdly, the specifics of educational, experiential treatment techniques draw heavily on learning and behavioral theory. These approaches predominate in the instructional components, including graduated pleasuring assignments. Reduction of anxiety about sexual matters is a planned part of educational exposure. Sexual complaints or dysfunctions are not always indicative of other pathology, be it personal psychopathology, pathological interactions, or organic difficulties. In some instances, sexual dysfunction may exist as an entity itself and not necessarily as a symptom of anything beyond ignorance, poor experience or cultural myths.

Sexual functions have, in this society, been so shrouded, contaminated, exploited, abused, exaggerated, prized and cherished, that assessments of complex etiology and symptomatology are often elusive. Sexual problems may co-exist with personal or relationship

pathology of a different order without implying casualty. Two distinct courses of treatment may be recommended, concurrent or sequential.

Selection of an effective approach for a couple requesting sex therapy includes, then, individual evaluation and differential diagnosis, an assessment of the crucial relationship and some appraisal of cognitive and informational aspects. As with most symptoms, causes may be multiple, superficial, or profound, of ancient or recent origin. Candidates, as in any sound program, will be screened medically, and appropriate colloborative work, as indicated, undertaken when referral to or from another professional is a factor.

Intake and Assessment

The initial process is a typical casework intake with a couple or individual, i.e., identifying information is sought as is discussion of problems for which the client(s) is seeking help. Some inquiry about sexual satisfactions or difficulties may be introduced if the client(s) has not mentioned this topic. In spite of a sexually "enlightened" world, the usual couple or individual seeking help in this aspect of life is still burdened with prohibitions, guilt, and deeply felt disappointments in self and/or partner. Because

of society's equivocation around sexuality, the majority of clients have neither emotional comfort, sexual self-awareness, factual knowledge, acceptance of sexual material, nor a nonjudgmental view of human behavior. Empathy for a client, and sensitivity to subtleties are essential in the professional.

Through history-taking, the therapist must determine what has been the client's sexual experience, what current limits of personal and moral acceptability may also influence the treatment plan.[39] The history, often referred to as a "sex history," is actually a form of social work's psychosocial history, if all aspects of psychosocial experience including sexuality are acknowledged. Too often, in social work intake situations, no information is offered and none solicited about the sexual components of past life--both client and social worker sharing the broad societal proscription against open discussion of sexuality. The professional's reticence may be buttressed by theoretic convictions or genuine respect for the client's sensitivities as well as a fear that his own motivation will be misread, but such omissions are not in the client's best interest. Some authors even suggest a failure to address these issues early in therapy accounts for premature termination.[40] Such a situation of mutual denial is reminiscent of parents who avoid acknowledgment of sexuality to their children and then

report their children "never asked." As adults, these children are likely to speak with bitterness about their childhood ignorance and about the disapproving attitude regarding sexuality, imparted by their parents' silence and/or cautious neutrality.

The social worker needs, as always, to listen to the client's emphasis, sequence, and other clues as to the primary concern and precipitating factors, meanwhile assessing personality strengths and weaknesses, and personal or social resources in order to arrive at a differential diagnosis. Both client(s) and therapist must work to define the underlying self-determined goals of the client. The therapist, in candor, needs to share his or her views of steps (s)he deems appropriate and feasible as well as his or her rationale. Only out of that process can come satisfactory agreement and a working alliance (not necessarily in the technical sense).

In evaluating a couple's complaint some combination of conjoint and individual sessions are ordinarily scheduled. Where possible, the preference is for the couple to be seen together initially. That session affords some opportunity to observe interaction, the common or disparate views of their difficulty. Any sense of disloyalty, which sometimes occurs if one partner precedes the other ("I'm talking behind her

back") or defensiveness ("I don't know what he told you, but . . .") is avoided. In a positive vein, a couple approaching treatment as a couple, is more often imbued with a mutual spirit, shared responsibility and a common goal ("It's our problem.") The opening joint session is seen as symbolic of the potential unity, even if strains are apparent.

The usual next step is to arrange for an individual session for each partner. The beginning joint session occasionally provides information or an intuitive "feel" of which partner would relate more easily to which therapist. Other things being equal, if co-therapy is the format, the woman is seen by the female therapist, the man by the male. On balance, it appears that it is easier initially for the client to be more candid with the same-sex therapist. However, this is not standardized by any means and is subject to variables alluded to earlier. In any case, each client in this format has both male and female figures to relate to and for identification or role-models.

In essence, the individual sessions are for the purpose of assessment, as delineated, they provide opportunity for the client to confide, question, ventilate and react to the therapeutic process. It seems superfluous to remark that clinical acumen and skills are vital in dealing with often previously taboo sexual material.

The social work tenet of nonjudgmental acceptance of the client is surely the underpinning for this process. To be effective, ultimately, the client(s) need to experience growing trust in the clinician and some greater comfort with his/her own sexuality. The experience of confiding itself is often therapeutic and, additionally, may afford an opportunity for education.

When an individual assessment is completed, the couple meets again with the therapist(s). The latter takes responsibility for outlining the recommended plan for treatment, first inviting the couple to address any recent developments, reactions or questions. There is frequently a good deal of tension at this planning session since the couple may be apprehensive about the outcome of the evaluation process and future treatment. Because of the power of sexuality and social attitudes toward it, attendant self-investment, and concern for the relationship, client vulnerability is acute at this point. Delicate clinical skills are called upon in such sessions; to approach planning and/or factual information without dealing first with the anxiety is generally inefficient and foolish.

The social worker(s) must perceive the defenses and resistance(s) in each of the couple; each therapist must demonstrate recognition and appreciation for the

feelings and wishes of each client. To be able to describe the suggested course of treatment without overelaborate detail (since it may vary as the case unfolds), and yet not so vaguely as to increase anxiety and ambivalence is incumbent upon the therapist(s).

Generally, the recommendation of most therapists, depending on the case requirements and treatment preference, falls into one of three categories: (1) a course of relationship therapy (either conjointly or concurrently, group or individual, or some combination), (2) a course of individual treatment (for one or both clients singly or in group), (3) a course of conjoint sex therapy involving the couple (conjointly or in a group). In each instance, the possibility is held open that any additional problems can be addressed subsequently. No effort is made to gain concurrence with the recommendation at that time, although frequently couples will volunteer that they wish to proceed. Wise practice suggests they be invited to discuss it among themselves and to relay their decision later.

Selection of Therapy

No doubt the single most difficult therapeutic consideration for the social worker or other practitioner of sex therapy is that revolving around the distinction and overlap between marital and sexual problems. While

certain guidelines are offered, thorough theoretic basis for clinical judgment is still absent. At either extreme, recommendations are less troublesome; if the couple's marital function is clearly imperiled by sexual difficulty, sex therapy can be seen as the initial treatment of choice; if sexual union is precluded by severe strains in the marriage, then marital (or individual) therapy may be recommended. The difficulty is, of course, in the middle group where cause and effect are indistinct, perhaps neither sexual nor marital impairment primary or acute.

Often clients arrive with a preconceived notion about their "arena" of treatment, having sought out a professional whom they understand provides sex or marital therapy. They have, to an extent, already determined what type of treatment they wish for their difficulty. Frequently, the social worker is in agreement; at other times, such decisions require further evaluation and the clinician may ultimately counter the client's conviction. Self-determination is an honored precept of social work, but a concretistic application is seldom warranted. The extremes, when stated bluntly, are: the client(s) having determined for her/himself that (s)he wishes a certain type of treatment for sexual problems, will dictate the therapy; or the therapist, as the "expert," will decide unilaterally, what approach is best for the

client(s). Either extreme is shortsighted.

Because of the time-limited feature of sex therapy, and the prevalence of sexual disorder in the relative absence of other major pathology, many clinicians are inclined to recommend the usually briefer sex therapy intervention in those cases where it is consistent with the couple's wish and not inconsistent with their own appraisal. Having been candid at each phase with the clients that the cause-effect pattern in sexual dysfunction is not yet well established, the fully prepared social worker can remain available subsequently to be of help in alternative ways: that is, to offer psychotherapy, either individually with one or both partners or in conjoint work with personal problems or the general relationship. Sexual dysfunction may prove to be secondary to those strains or exist as an entity apart.

The benefits of clinical social work skills are illustrated in such cases where marital and sexual concerns are interwoven. Where these are intertwined, a common sense inspection suggests couples can either make love or fight but not both simultaneously. Hence, if "love-making" (sex therapy) is the focus, the "fight" (extensive marital therapy) must be temporarily held in abeyance. If the "fight" is too pervasive or immobilizing, then help for "love-making" needs to be

postponed, and the other issue, i.e., the "fight" must be taken into the therapeutic arena. Individual or relationship therapy is at times, necessarily divisive, especially in a short term perspective. Both processes, marital or sexual therapy, are, to a degree, predictable and valuable but each needs to be distinguished as the emphasis of the moment, i.e., the major thrust of treatment, since they can seldom be effective simultaneously. The clinician must develop judgment to aid in the distinction.

A major feature of sex therapy is the reinforcement of positive emotions, shared experiences, pleasure-bonding in an erotic and sensuous ambiance that has hopeful tones. A degree of therapeutic optimism is an agreed upon essential in all treatment; it is especially important in sex therapy because of the nature of personal and social attitudes toward sexual "failure." Robert Sollod notes in this vein:

> The nature of the dyadic relationship is relevant in sex therapy. When aspects of the relationship are problematic, it is incumbent on the therapist to reinforce the bonds of affection and support that do exist. When resistance is clearly due to problems within the relationship, it may be necessary for the therapist to focus on these before treatment can be effective.[41]

Flexible approaches are also consistent with social work's traditional stance of viewing the client's needs

individually and in the social network of his/her life. In "beginning where the client is," social workers have often overlooked clients' readiness to deal with the sexual problem, anticipating severe resistance, and have failed to help the client articulate truly where (s)he "is" maritally or sexually, or to consider a full range of treatment approaches.[42]

To illustrate these concepts, the author recently worked with a couple who declared initially that they needed "sex therapy," but as they were seen conjointly and individually, it was clear that no actual sexual dysfunction existed. Rather, the man's unresolved Oedipal issues prevented him from assuming an appropriate adult role. She, in turn, was an obsessive-compulsive individual, anxious and perfectionistic with a placating style toward her husband. His dependence on her had heightened with a change in her work shift; she became increasingly irritable and anxious, as well as depressed, by his passive refusal (or inability) to take over any household tasks as her changed hours indicated. The couple needed help, but in the light of their earlier satisfactory sexual adjustment "sex therapy" was a dubious solution. A combination of marital and individual therapy was recommended, a plan which they accepted. As other issues were addressed, sexual activity was eventually restored to the satisfaction of both without any of the usual

specifics of "sex therapy."

It is possible to argue that such a couple might have benefited from a program in sex therapy if it had been a more mutual wish. (She was, in fact, bitterly opposed, seeing his interest in "sex therapy" as part of an increasing demand on her, and had agreed to seek counsel only to placate once again.) The benefit hypothetically would have been consistent with the accepted goal of "removing" obstacles to sexual functioning; in this case the immediate obstacle was mutual repressed dependence and anger.

To elaborate, often a couple's anger is mitigated by sharing the mutual assigned tasks which afford each pleasure, reaffirm one's attractiveness, reopen communication in an atmosphere of sensuality and goodwill. Greater sexual knowledge, while not an essential to functioning in many instances, is usually enhancing. The temporary and selective ban on intercourse, for such a couple, serves, as it does in other instances, as a protection from demands, resulting often in a greater willingness on both parts to resume sexual activity by choice, and not from "duty" or intimidation.

Other arguments might also be advanced, but the point to be emphasized is that in the therapist(s)' judgment there was sufficient underlying personal and

interpersonal disturbance to render such an approach too superficial, bypassing major issues with short-term gains. The request for sex therapy proved an entree to more significant benefits to this couple. Incidentally, had the social worker/"sex" therapist not been qualified to offer alternative services, the discouragement to the clients of yet another referral may have thwarted the effort for help. Conversely, had they completed such a course of sex therapy without any attention to other issues between them, when these problems persisted or reappeared, they might have concluded theirs a hopeless situation; "we've already tried therapy and failed. . . ."

In this case, the couple, identifying their goals, moved from the request for treatment of the sexual complaints to a goal of "getting along better, so we can enjoy sex again," and rather readily dismissed their original demand. The therapists clarified the view that sexual performance was not the complaint, so much as was a "fight which happened to take place in bed." Husband and wife could appreciate that distinction and work proceeded around resolving the "fight."

Had they remained steadfast in their original request, in all likelihood, for reasons outlined above, a short-term sex oriented program would have been

attempted with them. The social worker, while not overly pessimistic in advance, could have registered an opinion that they might well want to attend subsequently to other issues, assessment of which could be made in follow-up appointments after the sexual course of treatment.

Other treatment decisions in sex therapy involve the format. These may vary from case to case and from therapist to therapist; some prefer weekly to biweekly sessions, others offer highly concentrated modes even with daily meetings. In some treatment programs certain phases are conducted in small groups which share primarily in the didactic aspects and hence resemble informal classes. Usually, in such groups no effort is made for personal disclosure or discussion of past individual problems or presenting complaints. Privacy is in the control of each individual who can discuss or not, as (s)he chooses, reactions to the content and materials; group process is not emphasized. Clinical judgment in selection of couples for such a group and skill in carrying responsibility for group progress is too extensive for consideration here. Not every couple nor every dysfunction lends itself to this group format, but where available and indicated it has been a valuable supplement or adjunct and in some instances preferable to the individual work.

Treatment Procedures - Pleasuring Exercises

If the therapist(s) and couple agree upon the suitability of proceeding with the course of sex therapy, the process will include structured assignments. These require privacy, allocation of time, agreement to observe a ban on intercourse, intimate body contact, and some self-disclosure--a sharing with each other a wealth of experience. While each case, depending on symptomotology and personality features, may utilize a variety of selected assignments, in many instances there is merit in having the couple go through every phase.[43] Specific activities described here are largely derived from the author's training with Hartman and Fifthian[44] who, in part, credit Masters and Johnson. Each therapist no doubt imperceptibly alters his or her "learning" from the "lesson." Nonetheless, the heart of the sex therapy is assignments for hand, foot, face, body and finally genital-sexual caresses. These may be and are modified as to pace, frequency and fashion depending on the individual or couple; for example, a utilitarian assignment for shampooing and bathing together may be appealing to a couple who are still uncomfortable about pleasure for its own sake.

Although perhaps a happy accident, the usual order and success of the caresses, seem to be partially due to a replication of some psychosexual developmental stages.

From the child's first efforts to grasp his external world through his hands, he begins to delight in mastery and tactile pleasure. As he proceeds to the phase of locomotion and separation/individuation, he cherishes the stability of feet and legs (and a contact with wider horizons). In further development, with a growing sense of self, an identity emerges (which for most people is perceived as centered in the face or head) and greater clarity or reality about that which his senses (eyes, ears, nose, mouth, skin) impart to him about his world. He begins to form a fuller picture of his total being and an integration of all his "parts" before he is ready, emotionally and physically, to engage in frankly genital sexual experiences. Consequently, when couples are directed to experience giving and receiving this series of exercises, they are perhaps engaged in an ontogenetic "review."

Enhancing and rewarding as those assigned experiences may be in and of themselves, for many couples they may also repeat long ago courtship experiences in a somewhat different fashion. Most couples hold or touch hands, talk and reveal some personal information (identity), play "footsie" under the table, dance or play. They hug, kiss and fondle before they enter

full genital activity. Following marriage, these casual but pleasureful contacts tend to be eliminated (especially by males who have been socialized in sexual "goal" orientations and who overvalue intercourse and orgasm per se), thereby setting up a situation which emphasizes sexual performance rather than sensual pleasure. This deletion can become the source for arousal and orgasmic difficulties in women and erection or ejaculatory problems in men. By instructing and directing couples in pleasuring caress activities, as valuable processes in their own right (with coitus proscribed), the therapist affords them the opportunity to experience or repeat personal, even preconscious and collective or universal courtship experiences of exploratory contact.

More fundamental yet is perhaps the emphasis on the value of human touch. All knowledge of human primate and mammalian life suggest that touch is our most primitive and urgent sense. Without touch, we may perish though other needs are met. Rene Spitz, Harry Harlow, John Bowlby and others from various perspectives have established the primacy, in infancy, of clinging and cuddling and the impairment, in adulthood, of full functioning, in its absence.[45] However, in Western Society, touch, especially between adults, has come to have an almost exclusively sexual

significance. This "sexualization" of touch severely limits, of course, physical contact of all kinds with varying comical, awkward, unfortunate or even tragic results. The accidental touch of elbows by strangers in a theater brings forth an embarrassed murmur of apologies. Males with each other combine pain--slapping or punching--to signal the nonsexual nature of their greeting. Sensory deprivation in this society, for example, among the lonely elderly, may be much more widespread than realized and contribute vastly to maladjustment.

In any therapeutic relationship, social workers and other professions are reticent to use touch for multiple reasons. A study recently reported on professionals who find touch a useful tool in their repertoire, with the intention of conveying caring, especially when clients are in crisis situations or expressing pain or sorrow.[46] The most single influential factor in the decision to touch is assessment of the clients' likely interpretation and the sex of the client. Regardless of other complex consideration, these findings emphasize to this author the sexual attitudes and social confusion surrounding touch; even "healing" touch is under suspicion.

The taboo on bodily contact is defeating in at least two ways pertinent here: first, many individuals for fear of being misunderstood are denied by or withhold

from others the exchange of comfort, warmth and empathy which is fundamental to human well-being, thereby depleting one basis for healthy functioning. Second, as touch is equated with sexuality, then sexual function may also become impaired with the affectional touch per se obliterated. Any physical tenderness is seen as a sexual overture and every embrace becomes suspect. This is the root of the common complaints, "X never touches me unless (s)he wants to get me in bed," or, "Everytime (s)he hugs me I get tense because I know what (s)he wants."

Conversely, if most touch is equated with sexual interest, then as touch occurs it is often concentrated on presumed erogenous areas. The performance goal orientation in sexual socialization tends further to promote touch limited to mouth, breasts and genitalia. These factors eventuate in caresses and contacts which often ignore the arousal potential of the entire body, narrowing the arousal "base" and placing demands on one set of organs without much of a "support" system. Sexual intercourse may become the exclusive expression of affection or empathy, further burdening its function with many overdeterminants. Clients in sex therapy, it is hoped, learn to discriminate needs, offers or requests for affectional touch from the sexual and to appreciate alternative methods of emotional expression as well as the sensuality of the entire body.

Self-touch is also vital as an adjunct in therapy. If introduced or conducted as a way to appreciate one's body and its capacity for perceiving sensation it can enhance self-esteem. Numerous techniques and assignments in sex therapy deal with this aspect of self-awareness. Self-touch (also equated with sexuality, i.e., masturbation) is frowned upon in this society. It is not unusual, especially for men, who traditionally do less grooming, to be astounded at how pleasant it is to massage their own faces. Women in therapy confide they have never before admired or even looked at or touched their vulva. Much has been written about the depersonalization or alienation of the body in the contemporary world; simple self-touch exercises can result in clients becoming generally more aware of a wide range of sensations with a reappreciation for themselves as sensual and sensitive. This process also offers enrichment in interpersonal relationships, heightening self-worth and autonomy. Additionally, the assignments provide a means for individuals to comprehend that the total body is expressive and receptive, i.e., that sensation is not exclusively a function of genitalia.

The mutual caress exercises, by definition, allow pleasurable exploration, conveyance of a wide range of positive feelings (affection, playfulness, joy, curiosity, tenderness, respect, etc.) without according

extraordinary or premature emphasis on the genitals as though they were "detached" from the person. The assigned process of giving and receiving caresses allows new subjective experiences and reexamination of any rigid roles, requiring any passive partner to become, on occasion, more active and, conversely, permitting any overactive partner the opportunity to enjoy the pleasures of receiving. The attendant verbal communications between partners and later with therapists are often significantly revealing of other strains and become a useful adjunct to other phases of therapy.

For a partner who has despaired of ever being sexually adequate for his/her mate, it can be deeply moving to realize that his/her caresses can, in and of themselves, afford pleasure. For the partner, whose fear was a personal inability to be accepting of such pleasure or sexual arousal--these experiences can be empathically reassuring. For the occasional couple or individual who derives little from or even dislikes a given exercise, learning through self-observation has occurred nevertheless. Further, there is almost always an alternative favored exercise.

One somewhat unusual assignment the author highly commends is called "spontaneity" (with credit to Hartman and Fithian).[47] To offset the structured

effect of assignments and any suggestion that love making is an assortment of quasi-mechanical steps, at one or more points in therapy, a couple is assigned a time to "do their own thing." That is, they are to agree upon an activity which will heighten their intimacy and to set aside a time to carry it out. Certainly this assignment, although usually given with some instructions about decision making processes, highlights the couple's unique communication and problem solving capacities and is revealing of their lives and values. Some couples, excited about their new discoveries, elect to experiment with a vibrator or buy a volume of erotica. Others agree to a game of tennis, a special meal, a quiet walk, reminiscing with a photo album, a purchase for their bedrooms--oils, a lamp, a waterbed. A few learn more about their pattern of disagreement.

Samples of oils and lotions may be provided by the social worker to encourage experimentation and discourage painful friction. In so doing, a gesture of "permission giving" and sensuality is added, often important for constricted or shy couples. Erotic components are often introduced through art, music, poetry, and the couple is encouraged to elaborate these for themselves. Whether the couple is working in a group or conjointly with the therapists,

assignments are individualized in various ways toward the achievement of a new level of personal awareness and/or function.

Educational Materials

A high proportion of adults even in this period of sexual candor have minimal sex education; hence an important part of any therapeutic program is cognitive. Because observation of sexual activity is largely taboo in this society, sexuality is one of the few, if not the only, major area of common life in which people are not encouraged or allowed to learn by watching directly. Yet most sexual behavior is learned behavior and often the social worker's role is as educator; in the broadest sense, education is an important component of any therapy. Educating, or more correctly, reeducating, adults about sexuality is a challenge and opportunity requiring knowledge, acceptance and some articulation by the therapist-teacher. Many pedogogical techniques can be employed, but the usefulness of these depends on the skill of the professional in timing, selection and application in the particular case. Readings, didactic discussion, charts and diagrams are all useful in their time and place.

Among the most essential materials in the experience of most therapists are some judiciously employed audiovisual materials--slides, films and tapes. While it is not possible to describe in detail the attributes and criticisms of the many materials now available to the professional, there is sufficient variety to aid, generally and specifically, in most therapy programs and with most complaints. The advantages are multiple; the implied permission and naturalness of looking at the human body with tastefully done photography goes far in offsetting guilt born of earlier prohibitions. If one has permission to look and to talk and to learn about oneself and one's partner then there is a greater basis for optimism.

If the authorities in the client's life (earlier, parents, presently, therapists) treat such visual experiences without anxiety or punitiveness, but with respect, interest, and reasonable curiosity, then a corrective atmosphere may obtain. Nomenclature and vocabulary may be introduced which aids the client in expressing personal or subjective experiences more accurately. Teaching itself is often clearer, more readily encompassed and shared between the couple. Lastly, the opportunity to illustrate some of the range of human sexual response and behavior is instructive in the same way any other subject matter

is learned by direct observation.

The therapists can articulate in behalf of the same sex person portrayed, and also advocate for the opposite sex, demonstrating empathy, ease and understanding. This type of exposition bridges "the battle of the sexes" (i.e., the myth that differences are so profound as to create inevitable dissension), offsets the universal pessimism about understanding "him" or "her." Female and male have much in common anatomically, and these features can be highlighted.

The "practicing" stage of other animals and of human children in other cultures is severely repressed in this culture and may contribute to the high ratio of sexual problems. The taboo on seeing sexual activity (professionals label it with a term denoting pathology, i.e., "voyeurism") may well contain the roots of dysfunction in some arousal states since it appears that sexual arousal in humans is more dependent on sight than smell which predominates in the lower phylogenetic orders.[48]

The social worker in the role of educator encounters, of course, initial resistance and discomfort with many participants. Audiovisual materials are seldom viewed by the client(s) alone; almost always others are

present. The therapist(s)' presence is essential to answer questions, deal with anxiety or other emotional reactions, to gauge the response and judge the pace of this phase of the program. The partner's presence or absence is a case by case decision, but is usually preferred for several reasons, not the least of which is the sharing of what is often a powerful emotional experience, or so that the information to which the couple has been exposed is identical. Any arousal which may occur has a natural target.

As a consequence of such exposure, anxiety is usually initially heightened; looking at sexual material is one taboo, looking at motion pictures is even less acceptable than the printed page or still slides, looking at such material in the presence of others may be even a stronger taboo. This discomfort usually subsides (so-called desensitization) and provides the client with selectivity (or resensitization) of responses other than fear or embarrassment. On the other hand, attendant guilt about looking is reduced by the presence of the therapist(s) and partner.

Use of other cognitive materials carries the same requirement for professional attention to the affective component. The physical assignments, as described above, necessitate clinical sensitivity to the individual

emotional reactions. The eliciting of various positive affects, frankly useful in effecting improved attitudes toward self and/or partner, is judiciously employed, and must be defensible cognitively. (For example, the selective use of poetry or music or a joke in therapy needs to make sense to clients and not be manipulative or capricious.) The careful, sensitive intertwining of these aspects of therapy depends on the art, imagination, clinical skill and judgment of the therapist(s).

Basic Themes

Emphasis is placed on physical and emotional intimacy, giving and receiving of pleasure, with substitution of pleasure for performance. While the inevitability of tension and hostility in intimate relationships is accepted, coping techniques are identified and expanded. Concommitantly, the individual self-esteem and autonomy are featured in certain other techniques or exercises, so that identity is not submerged but enhanced.

The common theme, i.e., "intimacy," suggests both emotional and physical closeness. Inspection of this concept affords an opportunity for the social worker to amplify the polarity and tensions in life between intimacy and autonomy. Psychodynamic understanding of

gratification and anxiety in mergers and the pleasure and fear in independence are central in these conceptualizations. Louise Kaplan, drawing from Jean Piaget, Mahler, and others, writes:

> Personal wholeness and integrity derive. . . from . . . aspects of our psychological birth. The . . . core experience of wholeness comes from . . . the heavenly dialogue of merging . . . . The second experience of wholeness . . . after the achievement of separateness . . . (is) more complex than the first because it includes all the varied emotions, thoughts, fantasies and values . . . involved when we relate to . . . in-the-flesh, actual persons . . . . Relatedness requires a whole self and a whole other. . . . (It) unites harmonies of oneness and . . . the vitality of separateness. Ultimately, every facet of human existence is reflected in these reconciliations.[49]

The ceaseless ebb and flow of closeness and distance in all relationships is critical to sexual satisfaction with its intimate unions, separations and reunions. While such interpretations or theory need not be expounded as such to clients, there is receptivity and relief to many in the recognition that complete harmony or "togetherness" is not a measure of worth, normality nor success in marriage, and that disruptions in intimacy (clashes, tensions, and distance) are inevitable, as is the need for privacy and individuality. Neither is the presence of these negative emotions indicative of love's departure. Rather, the derivatives of these processes can be accommodated constructively in a relationship. The role of hostility

may not be well understood in sexual attraction, yet few would deny that it has some contribution; anger contains "warm" feelings not unlike sexual reactions physiologically.

Wisdom is expressed in the folklore, i.e., the "fun" of fighting and making up. Limited as present theory may be, experience suggests successful sex therapy embodies some of that pragmatic knowledge. Routinely the course of sexual therapy "work" includes some techniques which enhance self-assertiveness, self-awareness, separateness, individuality. A stance is imparted that sexual appetite and needs, while having a strong theme of mutuality, still cannot be seen as incumbent upon the partner. Put another way, in some final sense, each person is responsible for his or her own sexuality; satisfaction is not a gift to be bestowed or denied by the partner.

The emphasis on individuality is conveyed in a variety of ways during the course of therapy: by simple exercises such as self-touch exploration of the entire body (not a genital masturbatory experience), by the maintaining of a private journal to reflect reactions and subjective experiences, by the nondemand pleasuring which necessitates greater concentration on one's own sensations, etc., and by the requisites of decision making, as well as by discussion in individual sessions.

The couple learns that sexuality may be defined far more broadly than the narrow goal of coitus, that each of them is similar and different, that they, as a unique unit composed of two individuals, have many ways to give and receive pleasure, that they can discuss, select and effect a more mutually satisfying sexual relationship for themselves. They need also to disagree effectively in their unique pattern.

Indeed, the spirit throughout successful therapy programs is that of individual alternatives, not absolutes. With all the variations of intimacy--physical and emotional--no one is limited to one type of performance, no single goal held supreme, no "right" way is taught. Sexuality does express such a wide range of emotions and is capable of satisfying so many varying needs that almost universally some alternative mode is possible; conflicting wishes need not produce permanent rifts.

For example, for some individuals, intercourse is a release of daily tension or even a soporific; for others, on occasions, it may be an effort to restore self-esteem or, between partners, to reestablish equilibrium after a quarrel. In still other instances, sexual drives seek "simple" reduction and the pleasure of orgasm. At times, "skin hunger" or a need for

physical closeness, or reenacting of past separation crises, may be motivators; in other examples, displays of power and dominance prevail. The demand for a certain position or caress may be seen as a plea for greater variety or the result of curiosity. With the infinite richness of human (intra- and interpersonal) experience and behavior, the possibilities are endless. There is always an alternative means of satisfaction if the therapist can successfully work through anxiety, rigidity, moral sets or misinformation.

Permission to "just" hold or be held without a sexual demand can "solve" some of the above posed problems; in others, freedom from guilt about masturbation or novel (to the couple) positions or contacts would provide solution; "talking out" rather than "acting upon" some other feelings would suffice in some instances--and in others, a quarrel about the "real" issues could be beneficial. The confusion around sex has left many individuals vaguely expecting that intercourse can and should be the solution for too many general and poorly defined difficulties in life.

Post Therapy

As the couple completes their specialized program, appointments are usually spaced at wider intervals, but

formal termination is not achieved until both people feel satisfied with their current sexual experience, i.e., they have met their own goals, not some externally imposed standards. Goals established in the initial contacts may have altered by the expanding self and partner awareness.

A couple whose earlier goal was for "more frequent sexual intercourse" may have shifted to the goal of more time for pleasuring each other with or without intercourse. Or a couple previously concerned about premature ejaculation may have learned techniques for prolonging intercourse, but may now decide what is actually more important to them are ways in which they can be close, more "in touch" sexually and emotionally. Still other symptoms, e.g. dysparunia, may have been totally mitigated by both males' and females' greater knowledge of female arousal patterns. Secondary impotence may, for example, have yielded because of the reduction in anxiety for man and woman about its meaning and their greater ease of conversing about their physical relationship. The symptoms may remain but no longer be an issue between the couple as they develop more acceptance of physiological processes, as for instance, the many women who are not orgasmic in intercourse without additional manual clitoral stimulation. Both husband and wife arrive at a new

perception of the phenomenon and are less critical of each other.

Couples are then often seen at wide intervals over a period of several months as they incorporate or consolidate gains from the specific sex therapy. This forestalls the resumption of destructive patterns and reinforces improved interaction. Follow-up work continues to emphasize the couple's ability to identify and use their own unique resources to afford pleasure and settle differences within their relationship. The social attitudes toward sexuality and sensuality have not infrequently resulted in the placing of these as low priority, to play only after work is done, or to give the "fight" eminance in the bedroom. By assignments, self-observation, mutual encouragement, and greater skill in constructive differing, a couple is often better able to find time for greater appreciation of their joy in themselves and each other as well as more effective resolution of differences.

Behavioral exercises appear an indispensable part of effective therapy since the goal is not intrapsychic restructure but alleviation of symptoms; however, the therapeutic process depends on psychodynamic concepts in evaluation, treatment planning and dealing with resistance. The desirability of combining these

approaches appears troublesome to many clinicians as discussed elsewhere.

Clinical social work skills can facilitate sex therapy as demonstrated herein; expertise in sex therapy when integrated can augment clinical social work practice by providing broader range of appropriate service for clientele. Certainly a proportion of couples will acknowledge a need for help in other areas of the relationship which can become the focus after sexual disorders have been directly heeded. If the social worker wishes to remain as primary therapist, obvious distinct advantages obtain.

FOOTNOTES

CHAPTER III

[1]Warren Gadpaille, The Cycles of Sex, (New York: Charles Scribner and Son, 1975), pp. 20-21.

[2]Gochros, "Sexual Problems in Social Work Practice", op. cit., p. 5.

[3]Evelyn Thoman and Elise Gaulin-Kremer, "Correlates of Human Parental Behavior: A Review," Handbook of Sexology, J. Money and H. Musaph, eds., (New York: Elsevier, 1978), p. 782.

[4]Margaret Mahler et al., The Psychological Birth of the Infant, (New York: Basic Books, 1975), p. 289.

[5]Harry Harlow, Learning to Love, (New York: Aronson, 1974), pp. 49-68.

[6]Erik Erikson, Identity: Youth and Crisis, (New York: Norton, 1968), pp. 139-140.

[7]Thoman and Gaulin-Kremer, op. cit., p. 781.

[8]Vern L. Bullough, "Sex and the Medical Model," Journal of Sex Research, XI (Nov., 1975), 301.

[9]Helen Pinkus et al. Education for the Practice of Clinical Social Work at the Master's Level: A Position Paper," Clinical Social Work Journal, V (Winter, 1977), 259.

[10]For one tantalizing theory involving cortical functioning, see Gwen Stephens, "A Theory of Sexuality," American Journal of Nursing, January, 1978, p. 74.

[11]L. Sharpe, J. Kuriansky, and J. O'Connor, "A Preliminary Classification of Human Functional Sexual Disorders," Journal of Sex and Marital Therapy, II (1976), 106.

[12]H. S. Kaplan, "Editorial," Journal of Sex and Marital Therapy, II (1976), 84.

[13]Bernard Apfelbaum, "On the Etiology of Sexual Dysfunction," Journal of Sex and Marital Therapy, III (Spring, 1977), 50-62.

[14]Jack S. Annon, The Behavioral Treatment of Sexual Problems, I and II, (Hawaii: Enabling Systems, 1974).

[15]John Money, "Paraphilias," Handbook of Sexology, J. Money and H. Musaph, eds., (New York: Elsevier, 1978), pp. 917-928.

[16]Diane S. Fordney-Settlage, "Heterosexual Dysfunction: Evaluation of Treatment Procedures," New Directions in Sex Research, E. Rubenstein, R. Green and E. Brecher, eds., (Plenum Press, 1975), pp. 54-60.

[17]American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (3rd ed.; Washington, D. C., 1980), pp. 275-280.

[18]A. F. Axe, "Editorial," Psychophysiology, I (1964), 1.

[19]William H. Masters and Virginia E. Johnson, "Principles of the New Sex Therapy," American Journal of Psychiatry, CXXXIII (May, 1976), 552.

[20]Arnold Kegel, "Sexual Functions of the Pubococcygeus Muscle," Western Journal of Surgery, LX (1952), 521-524.

[21]J. Semans, "Premature Ejaculation," Southern Medical Journal, XLIX (April, 1956), 353-357.

[22]See, for example, Albert Ellis, Humanistic Psychotherapy: The Rational Emotive Approach, (New York: Julian Press, 1973).

[23]H. Higginbotham and G. Farkas, "Basic and Applied Research in Human Sexuality," Handbook of Behavior Therapy, Joel Fischer and Harvey Gochros, eds., (New York: Pergammon Press, 1979), pp. 243-244.

[24]Helen S. Kaplan, "Sex Therapy: An Overview," Sexuality and Psychoanalysis, Edward Adelson, ed., (New York: Brunner/Mazel, 1975), p. 209. Emphasis added.

[25]See Paul Wachtel, Psychoanalysis and Behavior Therapy, (New York: Basic Books, 1977); see also R. H. Woody, Psychobehavioral Counseling and Therapy, (New York: Appleton-Century-Crofts, 1971).

[26]Harry Guntrip, Psychoanalytic Theory, Therapy, and the Self, (New York: Basic Books, 1971), p. 27.

[27]Herant Katchadourian and Donald Lunde, Fundamentals of Human Sexuality, (2nd ed.; New York: Holt, Rinehart and Winston, 1975), pp. xi - xii.

[28]Erwin Haeberle, The Sex Atlas, (New York: Seabury Press, 1978), pp. v-vii.

[29]William Hartman and Marilyn Fithian, Treatment of Sexual Dysfunction, (Long Beach: Center for Marital and Sexual Studies, 1972).

[30]Virginia A. Sadock, "Marital Therapy," The Sexual Experience,Benjamin J. Sadock, Harold L. Kaplan and Alfred M. Freedman, eds., (Baltimore: Williams and Wilkins Co., 1976), p. 502.

[31]Harvey L. Gochros, "The Sexually Oppressed," Social Work, XVII (1972), 16.

[32]Ernest Bruni, "Psychotherapists as Sex Therapists," Psychotherapy, Theory, Research and Practice, XI (Fall, 1974), 281; Helen S. Kaplan, The New Sex Therapy, (New York: Brunner/Mazel, 1974), p. 222; Fordney-Settlage, op. cit., p. 46.

[33] Kaplan, Ibid., p. 195.

[34]Fordney-Settlage, Ibid., p. 45.

[35]J. LoPiccolo and L. LoPiccolo, eds., Handbook of Sex Therapy, (New York: Plenum Press, 1978), p. 1233.

[36]Ian Alger, "Discussion of Helen S. Kaplan's 'Sex Therapy: An Overview'," Sexuality and Psychoanalysis, Edward Adelson, ed., (New York: Brunner/Mazel, 1975), p. 214.

[37]Bruni, op. cit., p. 281.

[38]Bullough, op. cit., p. 301.

[39]For example, a man who firmly believes that any masturbatory activity is a "perversion" is not likely to be tolerant of a therapist's suggestion that his nonorgasmic wife attempt self-stimulation. She, in turn, feeling his disapproval, would likely be retarded in her goal.

[40]A. Rosen et al., "Pretreatment Expectancies and Interview Content," Human Sexuality and Social Work, (New York: Association Press, 1972), pp. 114-116.

[41]Robert N. Sollod, "Behavioral Psychodynamic Dimensions of the New Sex Therapy," Journal of Sex and Marital Therapy, I (Summer, 1975), 339. Emphasis added.

[42]Rosen et al., op. cit., p. 115.

[43]This stance is criticized by some. See, for example, Higginbotham and Farkas, op. cit., p. 243.

[44]William Hartman and Marilyn Fithian, Directors, Center for Marital and Sexual Studies, Long Beach, California.

[45]H. Musaph, "Skin, Touch and Sex," Handbook of Sexology, J. Money and H. Musaph, eds., (New York: Elsevier, 1978), pp. 1157-1164.

[46]"Using Touch in the Therapeutic Relationship," Sexuality Today, III (April 7, 1980), 1.

[47]Hartman and Fithian, op. cit., p. 169.

[48]Mark Cook and Robert McHenry, Sexual Attraction, (New York: Pergamon Press, 1978), pp. 3-10, 121-123.

[49]Louise J. Kaplan, Oneness and Separateness: From Infant to Individual, (New York: Simon and Schuster, 1978), pp. 30-31.

CHAPTER IV

RESEARCH AND DATA

The chief purpose of this investigation is to determine the extent to which clinical social workers are prepared to address directly sexual disorders, and to incorporate relatively new techniques and scientific knowledge described under sex therapy.

As described earlier, psychosexual growth and social development are complex processes involving biological, psychological and cultural influences on the individual. For various reasons, only a few unique to this profession, social work has been tentative in direct approaches to sexual disorders. Clinical social workers in all settings encounter candid or veiled sexual issues in the lives of their clients. Professionally, clinical social workers are well prepared with basic concepts and skills to integrate specialized knowledge of sexuality in order to help individuals and couples toward improved sexual functioning.

In terms of specific education in sexuality, clinical social workers are unevenly prepared, unclear about client expectation, professional standards, and/or legal, ethical and theoretical issues involved. Sexual matters within client populations are, of course, dealt

with by clinicians in some fashion, e.g., ignored or explored, approached directly or indirectly, incorporated in treatment or referred out, or subsumed in other treatment emphases. The question then is not if, but how, clinical social workers attend to sexual problems.

The survey instrument was designed to obtain aspects of that information as well as to inquire into some factors which may influence the inclusion or exclusion of sex therapy, education, and counseling in clinical practice. In essence, this is a descriptive study within a comparison group.

Hypotheses

These hypotheses were formulated as the basis for the questionnaire and the examination of the data:

I. Clinical social worker's preparation to deal with sexual complaints is minimal as measured by:
    a. formal education and/or training or
    b. informal attention to literature or other materials.

II. Clinical social workers with specific

educational preparation in sexuality have:

a. found it helpful in their work; and

b. tend to include sex education, counseling or therapy in their practices.

III. Clinical social work practice more commonly includes sex education and/or counseling than sex therapy.

IV. Clinical social workers who have earned the MSW in the last decade more frequently include sex therapy, education and counseling in their practice than do others trained earlier. Age and sex of the social worker are not determinants.

V. Clinical social workers are adequately informed about legal aspects of sex therapy.

VI. Clinical social workers' expectation about the future role of sex therapy in the profession is vague.

VII. Clinical social workers are conversant with some techniques and goals associated with sex therapy.

VIII. Clinical social workers who include sex therapy share common theoretic and practice views distinct from those who do not include sex therapy.

IX. Clinical social workers accept some treatment features commonly associated with sex therapy: use of conjoint and co-therapy, symptom-relief, time-limited modes.

X. Clinical social workers reject some treatment features commonly associated with sex therapy: use of directive, didactic, behavioristic interventions.

XI. Clinical social workers' comfort with varying client populations is not an acknowledged factor influencing inclusion of sex education, counseling or therapy in practice.

XII. Clinical social workers disapprove of erotic touch with clients regardless of their acceptance of:

a. sex education, counseling or therapy in practice.

b. non-erotic, (e.g., "comforting") touch with clients.

XIII. Clinical social workers assess case material at variance from stated theory or conviction.

XIV. Clinical social workers deal with sexual complaints more indirectly than directly.

XV. Clinical social workers regard sexual complaints and formulate related treatment plans as if such disorders were symptoms of other psychopathology.

Methodology

An early pretest instrument was devised for interviews with a group of colleagues in mid-1978; a second version was administered with the help of an associate in October 1978 during the Society for Clinical Social Work's Ninth Annual Scientific Meetings. The data acquired was useful in refining a final version, especially as to demographic items. The preliminary trials revealed a general acceptance by social workers of sex therapy as a part of social work, and an uncertainty about the presumed behavioristic slant of such interventions.

Revisions were made in the scheduled questions with expert consultation, and certain decisions were incorporated; notably, that the final instrument would be self-administered, that case material was to be included, and that a number of general items could be added to test out other information or rationale.

Lastly, it was determined that the population surveyed would be drawn from the Doctoral Program of the Institute for Clinical Social Work, all of whom hold Master of Social Work (MSW) degrees, are licensed, advanced practitioners, represent a wide geographic distribution within the State, and are by definition alert to ongoing education content in the field. No claim is made that this group is a representative or random sample of the entire clinical social work profession. These respondents are recognized as unique--indeed, an unusually motivated group of advanced student/practitioners. Nor was any ascertainment of respondents' sexual preferences, marital status, religious or racial backgrounds attempted as is frequently the case; this group was viewed as clinicians whose personal attitudes were not an issue. Underlying sexual attitudes or biases were not subject to inquiry, although one might speculate as to whether emotional forces subtly color responses and help explain some apparent inconsistencies.

Demographic information requested was limited to (1) age, (2) sex, and (3) date of MSW. (Since participation in the survey was limited to this highly specialized group of clinical social workers whose minimum skills and backgrounds had been established by their admission to the doctoral program). Additionally, a section 4) was included outlining the respondent's educational background, as it pertained to reading and courses in sexuality and/or training in sex therapy, plus any application in the respondent's practice.

While, in discussion, some effort will be made to distinguish sex therapy approaches from sexual counseling and/or education, no rigid line can be drawn, since the latter two invariably comprise elements of the former. The reverse is also true: counseling and education are therapeutic. No definition of sex education/counseling/therapy was provided in the schedule of questions because the intent was to allow each respondent his or her own interpretation of what she/he does or doesn't do.

Case vignettes, while altered, were drawn from the author's experience, representing situations in clinical practice. Two are initial interviews with individuals presenting complaints of a sexual nature: one a divorced man, the other a married woman. The third is an ongoing individual case which offers more complex issues

in terms of the situation in that the initial focus and concern were not sexual; further, more history is available in this case and several psychotherapeutic sessions have transpired. The purpose of this range was to provide information on how respondents would assess and deal with both initial requests involving sexual problems and those which might arise in the course of other treatment.

In the use of case samples, as in any therapeutic intervention, multiple factors on the part of client and social worker overtly and covertly influence the diagnostic impressions and choice or emphasis of treatment. This study does not propose to attend to all possible variables.

A section of general statements requiring agreement or disagreement was also included. These statements ranged over theoretical convictions, information, professional preferences, modes and opinions. These data constituted an opportunity to assess the respondents' acceptance or rejection of some of the aspects of sex therapy and afforded an additional dimension for viewing theory and practice. Because theory is highly complex and evolving rapidly in this new field, no claim is intended that theoretic considerations will be all inclusive.

In all, possible responses range from a minimum of ninety-seven to a maximum of one hundred twenty-seven if each were answered as intended. In detail, the three sections contain:

1. Three case vignettes with a total of fifty-five items regarding views of the case and possible treatment plans.
2. Thirty-two general statements requiring agreement or disagreement.
3. Demographic information of age, sex, year of MSW and eight major questions on education and practice in sexuality, with subsections where applicable with forty responses possible.

The final instrument was pretested with the help of colleagues in February 1979; the sample was taken in mid-March 1979 using that form.[1]

Demographic Data

Of the thirty-six individuals participating, two returned comments sufficiently incomplete so as to be excluded from computations. The final sample consisted of ten males and twenty-four females whose ages ranged from the sixties to the thirties. The older members of the sample were born pre-World War I, the younger, post-World War II; the youngest seven members in this sample were born after several members of the group

were already in practice. At the time of the survey, all were either doctoral students, faculty or staff of the Institute for Clinical Social Work, active in their profession beyond roles in the Institute and licensed clinical social workers.

TABLE 1*

PRESENT AGES IN DECADES

Age	Individuals
30-39	3
40-49	10
50-59	13
60+	3
48 (mean)	33(N)

*One female respondent declined to provide age or degree.

Master's degrees had been earned as early as 1939 and as recently as 1973 with the 1950's most frequent, i.e., median, mode, and with 1959 as a mean year.

TABLE 2*

DECADE OF MSW DEGREE

Year MSW Earned	Individuals
1930-1939	1
1940-1949	4
1950-1959	13
1960-1969	8
1970-1979	7
1959 (mean)	33(N)

*Ibid.

Specific Preparation

Only two individuals had had any course in human sexuality, required or elective, in graduate or undergraduate work. Twenty-four respondents had, since graduate school, taken some courses in general human sexuality. Most courses were taken in the years 1971-1975. Of those indicating such course work (N=24), only three had courses over thirty hours in length. For a third of those (N=8) course length was under fifteen hours. Twenty-one declared that these courses had been helpful in their work. At the time of the survey a majority (N=19) had not yet, to their knowledge, completed the ten-hour BBSE requirements for relicensure by 1980. Specific training in sex therapy was claimed by eight respondents, with time invested ranging from one to fourteen hours (N=3), fifteen to thirty hours (N=2) and thirty to seventy hours (N=3); all felt it to have been helpful in their work.[2]

The sample group demonstrates its overall voluntary interest in continuing education including sexual information, since the bulk of their course work in this field was undertaken prior to definite legal requirements for relicensure.[3] Little consensus obtains as to what constitutes adequate preparation in

the sexual field, especially sex therapy. Nonetheless, and in the absence of any absolute standards, the degree of thoroughness of preparation in this sample group must be questioned. The maximum indicated in training for sex therapy was thirty to seventy hours by only three respondents.

In response to a direct question, "What, if any, specific readings in the sexual field have you found helpful in your work?", a wide variety of readings were noted.[4] Somewhat startling was the apparent acknowledgment by over one-fourth (N=9) of no readings. One could speculate that perhaps whatever reading done by this group was either not directly related or helpful to their work, or that there was not sufficient interest to answer a fairly demanding question. Still, one wonders if this item is revealing of a coolness or lack of interest toward this field on the part of the respondents. Particularly arresting is the paradox with this sample's high level of commitment to "keeping up" with the field. Four of these nine were from a segment having had no course work in sex education and having not included it in practice; the remaining five had all had courses or workshops. In a related question about materials used in dealing with sexual concerns of clients, nearly 50% (N=16) replied that they use none, the remaining eighteen indicated use of various resources (diagrams,

charts, films, slides, and books) with books predominating (N=17).

Practice

Sex education or counseling is included in practice in one degree or another by 68% (N=23); examples of comments are revealing:

"As a minor adjunct to psychotherapy."

"Believe it is or can be important and integral part of social work treatment."

"Mere mention of my availability to discuss yields positive results."

"Issues arise inevitably in work with couples."

"As an integral part of therapy process."

"Helps make clients less anxious."

"It's a part of human functioning, appropriate to eliminate concerns."

"I think it is part of treatment."

"Many couples and individuals ask for this focus."

"It is essential."

Those who did not include sex counseling or education in their practice were less likely to comment; however, typical responses were:

"Not knowledgeable or interested in learning. Prefer to refer out."

"Do not feel qualified."

"Only deal with it as any other issue in treatment."

"Only as an integrated part of treatment."

"Not unless I feel it is related to the problem."

"I do some general education not applicable to work."

Seemingly, a proportion of those who replied in the negative do in fact deal with these matters on a basis similar to those who answered positively. Compare such statements as "Yes, as an integral part of therapy process," with "No, only as an integrated part of treatment." Identifying these components of practice as sexual counseling or education may have suggested a separated aspect to some respondents. The author presumes the portion who actually included the elements may be higher than the 68% noted.

It is equally interesting to note that the twenty-three who indicated that they offer education or counseling are <u>not</u> entirely synonymous with those who have had formal courses. At least four individuals do so without benefit of instruction but note their readings as a source of information.

In response to questions regarding sex therapy and practice, about 20% (N=7) indicated some inclusion. Of

these, all but one indicated some formal training. (That individual has apparently relied upon reading.)

A sample of relevant comments from those who engage in sex therapy includes:

"When it fits together with other work."

"Had to be, necessary."

"Other therapeutic endeavors will not be of benefit and are not indicated."

"I see many individuals and couples with problems in sexual functioning."

"Where it applies in general psychotherapy."

"Only as an integral part of treatment."

Those replying negatively are quoted as follows:

"There hasn't been a reason."

"Not what I am trained or prefer to do."

"Others are more competent."

"Incompetent, if needed, I refer."

"Too narrowly behavioristic. No acknowledgment of treatment relationship issues."

"I see sexual dysfunction as symptomatic of interpersonal and communication difficulties."

"Problems are interactional."

"I do not try to work with behavioral techniques as a primary focus."

"I am not trained as a sex therapist, but do offer

suggestions or ideas."

"Not interested."

"No co-therapist."

"I work with underlying dynamics and feel sexual problems become resolved as clients feel better about themselves."

Beyond a recognition of inadequate training (the most frequently expressed reason for a "no" response, occurring approximately ten times), the comments reflect some theoretic convictions: first, an exclusion based on the belief that sex therapy is "behaviorist" and does not attend to treatment relationship issues or underlying dynamics, and second, the opinion that sexual dysfunction is symptomatic of other issues. Self-esteem and interpersonal, interactional forces are enumerated by those respondents. No one directly comments on a belief that such dysfunction is necessarily symptomatic of intrapsychic psychopathology. Several of course, are frank in stating a matter of personal preference. The absence of a co-therapist, cited by one individual, may be either a theoretic or practical objection. Although the survey is not directly comparable to Schultz'[5] or Len and Fischer's work,[6] these findings support lack of training as an important deterrent. No one volunteered issues of legal, agency or professional sanction.

Those who include such therapy see it as an integral part of services, in demand by clients, and the treatment of choice in some instances. There is a flavor of inevitability and acceptance of the need, best expressed by the observation, "It comes up everyday as an important and natural part of loving and treatment." This subgroup did not address theoretic matters other than by implication since for them, apparently, there is no conflict with their general view of treatment. In part, this may be attributable to their greater exposure to and knowledge of sex therapy which has reduced or removed the fears of its presumed narrowly behavioral elements.

Clusters or Subgroups

It was possible to identify three major clusters:

1. A cluster numbering eleven, almost exactly one-third (32%) of the sample, is composed of two related but different subgroups. One, those who include in their practices neither sex education, counseling nor therapy (N=5), were, for convenience designated as "Conservatives." A related, but different group (N=6), while having some classroom work, likewise do not incorporate sex education, counseling or therapy in their practices; these were abbreviated

as "Traditionals," for reference.

The mean age for these eleven (Conservative/ Traditional) individuals was fifty-three; the mean year of MSW degree, 1954. Only one respondent in the age range of the thirties is found in this subgroup; all but one of those in their sixties in the sample are located herein. No one in this cluster obtained the MSW as recently as the 1970's.

2. A second major group totaling sixteen, nearly 50% of the sample, is also comprised of two subgroups. One consists of thirteen individuals who have undertaken courses in sexuality and incorporate some sexual counseling or education, but not therapy, in their practices. Combined with a minimum group of three respondents who without formal instruction have pursued independent sources and include sex counseling and education in practice, these sixteen respondents are referred to as "Conventionals." Their average age (computed with N=15 since no age or degree data was provided in one instance) is fifty-two, with a mean for MSW degrees of 1960. Their weight determines most responses; they represent the "average" current practice and are 47% of sample.

3. Seven respondents include sex therapy (as well as education and counseling) in practice; six of these have had some exposure to specific training and education. The term "Contemporary" is applied to this group whose ages averaged forty-four. This cluster represents 21% of the sample. While MSW's were earned in the 1940's, 50's and 70's (but none in 1960's), the mean for the degree is 1962.

While age in and of itself may be a factor in selection or emphasis of technique in one's practice (as seen in contrast between groups one and three), the more consistent variable is the era of degree, with a clearer progression toward inclusion of more innovations on the part of those whose Master's level education was more recent. In fact, of the seven in the Contemporary group, four had received the MSW in the 1970's. However, in the Conservative/Traditional groups are also seen a few individuals whose degrees were from the late sixties, so that factors other than time are evident as influences. That Masters-Johnson's publications became widely known in the early 70's may help account in part for this latter finding, and the fact that all seven individuals who achieved the MSW in the 70's include sex education and counseling, if not therapy, in their practices. Subgroups compare as follows, in Table 3:

TABLE 3*

AGE, YEAR OF DEGREE, AGE AT DEGREE, YEARS IN PRACTICE, BY SEX AND SUBGROUP

Individuals		Mean Age	Mean Year MSW	Mean Age at Degree	Mean Years in Practice
Females . . .	23	50	1956	28	17
Males	10	43	1965	29	14
Conservative/ Traditional .	11	53	1954	28	25
Conventional.	15	52	1960	28	19
Contemporary.	7	44	1962	28	17
Total. . .	33	48	1959	28	20

*One female respondent declinded to provide age or date of degree.

The ten males in the sample, when taken as a group, are substantially younger (only one is over forty-eight) with a mean age of forty-three; only two MSW's predate 1968; three are in 1970. Over all, however, with few exceptions they replicate the larger sample in their responses. In terms of age and time of MSW, they correspond closely to the Contemporary group, but appear more Conservative/Traditional than the females in this table:

TABLE 4

COMPARISON OF MALES-FEMALES BY SUBGROUP

Sex distribution	Conservative/ Traditional	Conventionals	Contemporary
Females (24). . .	29%	50%	21%
Males (10). . .	40%	40%	20%
Total (34). . .	32%	47%	21%

The total female portion of the sample had an average age of fifty, younger than the Conventional cluster, but had earned their degrees earlier than that group, i.e., more nearly resembling the Conservative/Traditional group.

Profile and Summary

The "typical" respondent in this study presents herself

as a forty-eight-year-old female clinical social worker who earned an MSW about twenty years earlier. She did not have any courses, elective or required, in human sexuality as part of her undergraduate or graduate work. In the period from 1971 to 1975 she attended some minimal courses or workshops on the subject (which she finds helpful in her work), although at the time of the survey she had not completed a course she believed would qualify her for the BBSE 1980 requirements. She includes in her practice some sexual education and/or counseling for her clients and owns some pertinent books. She herself has found certain authors helpful in this phase of her work, notably nonsocial-work authors, especially Masters-Johnson and Helen S. Kaplan.[7] She most closely resembles the Conventional subgroup described above.

Hypothesis I through IV may be examined, thus far, and upheld. As a total group, clearly committed to continuing education and advanced practice, there is little indication that knowledge rapidly advancing in this new field has held substantial attention for most as expressed by formal participation in classes. (A majority of the sample would be in all likelihood increasing their course work, nonvoluntarily, this year because of 1980 relicensure requirements.) Those providing sex therapy do not have training in any great depth by whatever measures regardless of any final

standards in the field. In short, there is no evidence of other than minimal preparation, as anticipated in Hypothesis I.

Individual or informal attention or investment of time and effort as measured by reading and acquisition of materials is not only uneven, but especially deficient in overall pursuit of pertinent literature. Those who have been exposed to courses or reading have indeed found it helpful in their work, as expressed in Hypothesis II. Those with sex education--as hypothesized--are more likely to include sex education, counseling or therapy in their practice. However, the relationship is far from clear. While it is true that two-thirds of the sample include some of the components in their practice, four (17%) of these have no related formal education or training. Also there are six respondents in the sample who have some educational background but disclaim any usage. Hence, nearly 30% of those surveyed do not follow the anticipated pattern. (These data do not reveal possible motivational sequences, i.e., whether education preceded interest, and practice innovation, or vice versa.)

The greater incorporation of sex education and counseling as opposed to sex therapy (Hypothesis III) was borne out. Sex education and counseling, as less demanding

interventions, are more readily incorporated as a part of practice.

Era of MSW degree appears indeed to carry more weight in determining practice patterns than does chronological age as foreseen in Hypothesis IV. While the sex of the respondent seems without true significance in this small sample, females, though older, were less conservative than males.

General Survey Data

In exploring the further nondemographic data in detail, no attempt was made to correlate all items, but rather to extract certain patterns which would be descriptive of the knowledge, opinions, theory and modes of practice among this sophisticated group of clinical social workers, and which would pertain to hypotheses.

Items number #3 and #12 of the general information sheet,[8] "Those practicing sex therapy in California must, by State law, be licensed and have specialized training," and "Use of sex surrogates is specifically unlawful in California," neither of which is true, were included to assess knowledge of legal requirements in Hypothesis V. In this instance, fewer than 50% of the respondents were aware of the accurate responses,

so that the hypothesis fails. Item number #3 evidences confusion in the field; four respondents were undecided, while the other thirty were evenly split, including an exact distribution between those practicing sex therapy, who might be expected to know the law, and the other extreme, those declaring no special education nor experience, who were equally accurate or inaccurate as the presumably more knowledgeable group.

The item (#12) regarding surrogates is further revealing of either ignorance or possible bias, since over one-third of the respondents were undecided and five agreed that use of surrogates is specifically unlawful. Less than half (N=16) were able to disagree (accurately) with that statement. Three who disclosed their confusion were self-listed as in the field of sex therapy, as were an equal number of those who had no education "exposure."

Uncertainty about the future relationship between clinical social work and sex therapy was also tested in certain items. For example, it was estimated that respondents who agreed with item #2[9] "Current interest in sex therapy is a passing professional fad," might well be those who chose to exclude it from practice and/or who had had no exposure to the field. Interestingly, only <u>one</u> of the Conservative group agreed

with that statement, while half of the Contemporaries were undecided. In all, nearly 60% do not dismiss this treatment as a "passing fad."

Item twenty-nine,[10] "The current interest in sex therapy indicates that such techniques are becoming a standard part of clinical social work," is one of the items where attitudes more clearly correspond to personal background (or vice versa) in that the more conservative group "voted" nearly as a bloc that sex therapy techniques were not becoming a standard part of social work. The Contemporaries on the other hand were also consistent in their agreement with the opposite view.

While a majority (52%, N=18) agreed that these techniques were becoming a standard part of clinical social work, nearly as many were either in disagreement or undecided (N=16). This seems to reflect the state of confusion and uncertainty referred to elsewhere. Comparing item #2 above (the faddish potential) with the slightly different totals (60% and 52% respectively), one might conclude that some respondents, while not viewing sex therapy as a passing fad, nonetheless resisted the notion it should or would become a standard part of the social work profession.

This latter item, #29, however, differentiates between

the Conservative and Traditional groups, in that the Traditionals, while not including sex education, counseling, or therapy in their practices, have had some specific educational exposure in contrast to the so-called Conservative group. The Conservatives do not (with one exception) see the future of clinical social work as including sex therapy as a standard technique. The Traditional group (with one exception), while not electing such practices for itself, differs from the Conservatives regarding future inclusion for the profession. This is the only instance of distinct cleavage between these two groups, giving rise to speculation about the motivation for and outcome of their differing educational experience. The notion of divided opinion expressed in Hypothesis VI is confirmed.

Items connected with Hypothesis XI addressing issues of comfort are not especially revealing, probably because most professionals are resolutely self-aware of their acceptance of clients, and their ability to work with a broad segment of humanity is a point of pride. In every item, a majority staunchly denied being more comfortable with one than the other of the choices. (By extension then, might one say there was equal discomfort with sexual issues in any situation?) See Table 5.

The greatest spread was shown in the answer to item #19,[11] where at least ten people acknowledged some greater discomfort with homosexual clients. In descending order are #18[12] where six acknowledged more comfort with same sex clients (two undecided); item #28,[13] where three made clear that they were more at ease with their own race (three uncertain); and #23,[14] where couples were easier than individuals for two respondents (with six unsure). Age and marital status were significant to only one respondent in each category,[15] while six questioned their comfort about age (item #25),[16] and only one was undecided as to comfort with married or unmarried clients (#30).[17] Item #14[18] brought forth a unique response where no one claimed greater comfort with homosexual clients of the same sex (with four undecided); all others (N=29) denied any variation. Perhaps this preponderance reflects greater discomfort with a client of one's own sex depending on the threat homosexuality poses to the therapist and the therapist's own sexual preference. On the other hand, it may convey a degree of discomfort with any homosexual client.

Except for an occasional "undecided," those with sex therapy and counseling background asserted in a bloc that they were not more (un)comfortable with any population over another. While this may represent a prevalent wish to idealize, it may also truly represent greater desensitization to sexual issues and consequent

reduction of anxiety. No other subgroup patterns emerged, nor can further conclusions be drawn in a small sample; Hypothesis XI appears confirmed.

TABLE 5*

COMFORT WITH CLIENT VARIABLES

I am more comfortable discussing sexual material with a:	Greater Comfort	Undecided	No Difference in Comfort
Heterosexual client than with a homosexual client.	30%	15%	55%
Client of my own sex than the opposite sex.	18%	6%	76%
Client of my own racial background than of another race.	9%	9%	82%
Couple than with an individual client.	6%	18%	76%
Much younger client with a much older one.	3%	18%	79%
Married client than with an unmarried client.	3%	3%	94%
Homosexual client of my own sex, than the opposite sex.	0%	12%	88%

*Appendix B, pp. 217-218, items #14, 18,19, 23, 25, 28, and 30.

Another group of items was designed to test familiarity with concepts specific to sex therapy and therapists. Chief among these are items #1, #6, #9, #10, #11, #15,

#20, #21, and #24 relating to Hypotheses VII and VIII. Those familiar with sex therapy recognize that disagreement with item #1, "Sexual dysfunctions, where not organically based, are symptoms of underlying psychopathology,"[19] is consistent with a growing conviction in the field. Test results are noteworthy in at least two ways: first, a slim majority (N=19) disagreed with that item indicating less than total group adherence to pure psychoanalytic precepts, and secondly, those respondents who place themselves in the sex therapy field are equally divided and hence, either poorly informed in the field or uncertain about their theoretic posture.

Goals of sex therapy are referred to in items #9 and #20.[20] Number nine often represents the uninformed or the prejudicial view that "Sex therapy instructs people how to function." In fact, the thrust of the literature and experience in sex therapy underscores the assumption that sexual functioning is an innate capacity and, where nonorganic dysfunction is present, the "Goal is to remove obstacles" (item #20) to permit that system to become functional. Obstacles may be ignorance, poor learning, intrapsychic conflict, interpersonal strains, social-cultural pressures, etc. Consequently, one would expect an oppositional (to sex therapy) or uninformed respondent to agree with #9 and perhaps

disagree with #20. Instead, this sample agrees heartily with both! (Item #9, N=22; item #20, N=30). Those who do disagree with item #9 include some of the Contemporary group, but no consensus or pattern emerges. In terms of item #20 which had near positive unanimity, two who disagreed claim to be sex therapists.

Item twenty-one challenges the belief that sex therapy cannot be recommended if there is overt evidence of psychopathology.[21] At least superficially, responses to this item could identify those who envision sexual dysfunction as always a secondary symptom (and who would wish to offer treatment for whatever they viewed as basic pathology). Yet preponderant agreement (N=26) held that sex therapy could be the treatment of choice, under the described conditions.

Number ten, "Sex therapy has little relevance to traditional Freudian and neo-Freudian theory,"[22] and #24, "To be effective sex therapy need not attend to the client's past history since the focus is current performance," address issues often in contention by those trained in psychoanalytic framework.[23] The author's position is to disagree with both items; as amplified elsewhere, psychodynamic and genetic considerations are a part of her view of sex therapy. In this sample, the majority (#10, N=21; #24, N=23)

shared that disagreement on whatever basis, as did some of the Conservatives/Traditionals, while some of the Conventionals and Contemporaries found themselves dubious.

The inaccuracy of the description of sensate focus (item #6)[24] was recognized by a substantial majority of all respondents, with only three individuals agreeing with that statement. Six were undecided, while twenty-five disagreed. Since the concept of sensate focus is one of the basics put forth by Masters-Johnson a decade ago, this group's discernment suggests a reasonably sophisticated level of information (or a freedom from misinformation) about this feature of sex therapy. Nonetheless, of those nine individuals who were undecided or in agreement, seven have had some formal sex educational work within ten years.

Number eleven, while less definitive, is also revealing of certain familiarity with procedures and assumptions in the sex therapy field. The notion that "Open hostility per se is a contraindication for sex therapy"[25] is not borne out in the literature nor the author's experience, so long as the couple wishes to work together toward resolution of sexual disorders. In fact, some authors hold that a component of hostility is essential to good sexual function and

appetite. Such wisdom seemed more uniformly apparent to some of the Conservative/Traditionals than the Conventionals or Contemporaries; however, a scant majority (N=18) disagreed with the statement.

The question of teaching masturbation ("Under some circumstances, I would teach masturbation techniques to a client," item #15)[26] is a "watershed" issue in that it is a generally accepted part of sex therapy, especially for nonorgasmic women and in some instances for the various male dysfunctions. A majority were in disagreement (N=15), about 36% (N=12) in agreement, and a large number (N=16) undecided. Of those who declared their support of the statement, all use some counseling or therapy in their practice; those opposed included almost all of those Conservative/Traditionalists (eleven individuals) who included no sexual counseling or therapy in their practice. Two of the undecided are among the "therapy" group, giving rise to curiosity as to how they treat such conditions. (Among some of the respondents, the question may have been misunderstood as referring to the <u>demonstration</u> or in-person <u>directed</u> instruction; if such meaning were inferred, it is impossible to assay the basis for that distortion.) Hypothesis VII is upheld; VIII is not.

A further group of questions, while by no means

exhaustive, probed in behalf of Hypothesis IX and X are stances connected with the forms or modes commonly associated with sex therapy, e.g., the use of co-therapy and conjoint or time limited therapies. Item #32 "Working with a co-therapist is a handicap to therapy since it 'dilutes' the transference,"[27] is not supported by a high proportion of the respondents (N=3). This clinical sample does not see co-therapy as a theoretical negative. When work in sex therapy is specified (#16, "Sex therapy with a heterosexual couple ideally utilizes a male/female therapy team")[28] nearly two-thirds of these social workers agree. That those subgroups indicating sex therapy as a part of their practice are less than unanimous is not surprising since those in recognized positions in the field differ in this regard.

Responses to items bearing on conjoint therapy also suggest a lack of theoretic opposition in the sample. Number twenty-seven, "Seeing the couple (conjoint) therapy is contraindicated because it 'contaminates' the transference,"[29] clarifies that a strong majority (N=31) no longer hold a former conviction regarding transference issues. In #13,[30] "When interpersonal, i.e., relationship, issues play a major role in sexual problems, treatment of choice requires seeing the couple as opposed to an individual alone," the weight

of opinion is toward seeing the couple if one is intending to work with interpersonal sexual issues (N=23). The Contemporaries are nearly unanimous in that instance.

By contrast, in item #5, nearly one-third (N=10) agree that "The most effective psychotherapy is one-to-one: i.e., one client, one therapist."[31] Six are undecided and only a narrow majority of 52% (N=18) disagree. There is less firm conviction that modes other than one-to-one are as affective forms of psychotherapy as, for instance, conjoint, co-therapy, etc. Possible explanations occurring are: that there is uncertainty that sex therapy is a part of psychotherapy, hence what is effective for one therapy is not treatment of choice for the other; or that, while no theoretic opposition exists regarding transference (contamination or dilution), the individual clinician's personal experience, style and preference renders that social worker more effective in individual treatment relationships. This latter notion is supported by the lack of clustering of subgroups (from Conservatives to Contemporaries) in this item.

The time-limited dimension of most sex therapy is, occasionally, offered as a basis for disapproval; this sample, however, does not hold such an approach as

unworthy. Findings in item #8 spell out support for such "contracting" as a valid technique (N=21 agree, N=8 undecided, N=5 disagree).[32] There was total agreement that "Brief therapeutic contacts can have long-term benefits" (#17).[33] It is noteworthy to find that among those who disagree regarding time-limited contracts are two of the Contemporary group, while one is undecided.

Certain items in the general statements were viewed as sensitive to some of the theoretical rationale postulated as a basis for inclusion or exclusion in practice, i.e., Hypothesis X. General postures toward directed interventions focused on specific symptoms were examined in items #4, #26 and #22, related to this hypothesis. Number four, "I would not include sex therapy in my practice because of its emphasis on behavior modification techniques and directing client,"[34] showed less than half (47%)disagreeing; i.e., sixteen individuals would not exclude sex therapy because of its behavioral or directive aspects. Close to one-third (32%) supported the item and would exclude on that basis. A full 20% were undecided. The Contemporaries themselves, as a group, disagreed with the statement, but, paradoxically, were not totally unanimous. Nor was the Conservative/Traditional group in full agreement, strongly suggesting this issue has

not been resolved or fully confronted. In Item #26, "I am skeptical of any therapeutic approach such as sex therapy which focuses on symptom relief,"[35] disagreement prevailed; close to two-thirds of the sample disclaimed skepticism, including nearly half of the Conservative/Traditional subgroups. Twenty percent did acknowledge doubt, including some who practice sex therapy. Nonetheless, in the total sample, a focus on symptom relief is not rejected, although this is a frequently registered criticism of sex therapy in some quarters.

The most marked theoretical disagreement was, not surprisingly, in those items pertaining to direct active intervention on the part of the therapist. Direct inquiry, item #22, "It is my practice to inquire early in my work with clients about their sexual functioning,"[36] is the stated practice of close to 50% of those polled; approximately one-third disagree, and over one-fifth are uncertain about their practices. Those including sex therapy and/or counseling are more likely to inquire; other subgroups do not show any particular consensus.

Number fifteen,[37] "Under some circumstances, I would teach masturbation techniques to a client," has been discussed above in another context, but in this vein,

i.e., directing clients, it is noteworthy to recall over half (N=21) were either undecided (N=6) or in disagreement (N=15). While it must also be recognized that content (masturbation) may introduce bias, only 36% supported directed "teaching" in this context.[38] This, interestingly, was the single question showing clearest polarity between the two groups, Contemporaries and Conservative with the Conventionals showing a "perfect" split distribution. Apparently something more than the mere question of degree of direct intervention is operating when compared to distribution in item #22, (see Table 6). In summary, both Hypotheses IX and X are valid.

TABLE 6

AGREEMENT WITH CERTAIN INTERVENTIONS

Intervention	Agree	Uncertain	Disagree
Instruction in masturbation. . . .(a)	36%	18%	46%
Inquiry into sexual aspects . . . . . .(b)	50%	20%	30%

(a) Appendix B, p. 217
(b) Appendix B, Ibid.

Hypothesis (XII) has to do with ethical concerns at time associated with sex therapy. The sample split almost evenly regarding nonerotic contacts, #7,"A nonerotic therapist-client physical contact, if acceptable

to the client, can be beneficial to the therapy,"[39] fifteen agreeing, sixteen disagreeing and three undecided. Again, the division did not positively correlate with sexual education, training or practice. Perhaps the half dozen sex therapists, a large preponderance of that subgroup who disagreed, are hypersensitive on that issue; no other pattern was discernible. As noted above, touch in general is a "touchy" issue. Hypothesis XII is upheld.

The lone person who agreed with item #31,[40] "An erotic therapist-client physical contact (including intercourse), if acceptable to the client, can be beneficial to the therapy," was not among the group who practices sex therapy. While the answer may have been a fluke since the same respondent answered negatively for non-erotic contact, Len and Fischer do report two comparably "unusual" responses with a sample of forty-five.[41]

There are, of course, therapists who hold such erotic involvement to be beneficial and therefore by implication ethical; this group of social workers was of an almost single mind in opposition (as is the author). In this sample, differences in ethical values tested seem unrelated to practice decisions about sex therapy. Usage, approval and ethical values bear upon each other in complex ways. Moreover, these, as Schultz pointed

out, are not static. His 1972 survey of social workers' attitudes found rather wide approval (60.9% and 44.9% respectively) of body and sex therapies although with expressions of concern about "involvement"; a low rate of usage (25.4% and 16.1% respectively) was reported.[42]

Those figures are comparable with the present sample in which 21% claim use of sex therapy. While not worded in this study to inquire directly as to approval per se, responses to the questions as to "faddishness" of these therapies or their becoming a standard part of social work are within range of Schultz' approval figures.[43] (See discussion of items #2 and #29 above.)

At this juncture Hypotheses V-XII may be reviewed in relation to this sample of clinical social workers. The group is not clear about pertinent legal aspects; Hypothesis V is not supported. Hypothesis VI is not upheld in that sex therapy is not seen as a passing fad but as becoming a standard part of clinical social work.

This population of social workers is conversant with some of the common concepts in sex therapy, such as sensate focus, treatment of partner unit, utilization of co-therapy teams. Hypothesis VII is borne out.

Hypothesis VIII is not, in that the sample is divided as to whether to inquire about sexual functioning early in their work with clients and is opposed to instruction about masturbation.

While addressing Hypotheses IX and X, both of which are valid, it is seen that short-term, time-limited therapy is well accepted, and little opposition to conjoint or co-therapy approaches is expressed, nor is the traditional one-to-one format idealized. While this group sees relevance between sex therapy and traditional Freudian theory (and is convinced that effective sex therapy needs to attend to the client's history), there is resistance or uncertainty about including sex therapy in its work because of the behavioral emphasis.

The data uphold Hypotheses XI and XII. This group does not express noteworthy differences in comfort in discussing sexual matters with variations in clientele. They are strongly opposed to any erotic contact with clients while somewhat more accepting of nonerotic physical contact; consensus is lacking.

Case Vignettes

Application, in practice, of theory and knowledge (however derived) determines the true state of an art or a skill; hence three case vignettes were included in the survey, for respondents' assessment and indication of treatment plans. While an imperfect device, case speculation allows observation of ways in which clinical social workers deal with clientele. In this instance, aspects of the professions' perspectives toward employing sex education, counseling or therapy with clients can be examined through case material. How special education, training or other factors influence decisions in treatment plans may be roughly compared.

Also case material provides an opportunity to determine whether expressed general opinions are consistent with or altered in practice as hypothesized. For example, the Conservative/Traditional group state that they do not include sex education or counseling in practice yet show some willingness to do just that when offered choices as treatment options. The Contemporaries, while theoretically recognizing sex therapy as a treatment of choice (even with evidence of other pathology), are, nonetheless, inclined to eschew direct help with a sexual problem.

As noted in the instrument, the statements pertinent to these cases are not, of course, mutually exclusive. Further, assessment of the cases or treatment plan choices presented is not to be thought of as all inclusive. Different views can be held simultaneously and contrasting treatment plans considered in abeyance as likely or unlikely. The author is well aware that some factors carry more weight than others, that equally competent social workers may differ in theory and/or style in similar cases, that resources may vary from setting to setting, and that custom or resistance may dictate therapies, that written descriptions can only approximate the essence and nuances of a client in person.

Respondents appeared to engage in thoughtful replies, adding comments, qualifications or alternate plans. The ever present frustration with written case material is, of course, the wish for more information and less definitive choices. The gist of respondents' comments was: "need more sessions to decide," "would want further evaluation"; or, in the case of "forced" choices, "don't like to generalize," "either-or is difficult." These expressions reflect universal problems with survey instruments and the imprecision in dealings with all human interaction. There is a wish characteristic of social workers--perhaps laudable, perhaps lamentable--to avoid hasty or pressureful decisions. In real life,

treatment hypotheses are formulated, decisions made and recommendations offered, under less than ideal circumstances--too little time or information--and yet still are identifiable as good clinical work.

The first case vignette (Case I) was presented to the respondents as follows:[44]

Referral source: Personal physician.

Presenting telephone complaint: "Trouble" adjusting to single life.

Presenting complaint in session: Impotence.

Howard, a robust 54-year-old man in the first session tells you he is experiencing some depression, anxiety and loneliness after the termination, six months ago, of his 34 years of marriage. He is surprised at his reaction since it was an unhappy marriage for many years after the kids left and he was "glad" she got the divorce. Howard, a stable blue-collar worker, was a faithful husband throughout all those years, but she constantly accused him of being a pushover for other women; he used to wish he were free. Now that he is, he frequents bars; women seem to seek him, but he can't get "with it."

In fact, the few times he has tried to be intimate sexually with women, he could not, for the first time in his life, get an erection. He is feeling very discouraged about a lonely future and embarrassed to try to make new sexual relationships. Although he has recently been seeing more of one woman he likes, he is threatened about the possible sexual failure and thinks he will change bars to avoid her and facing the issue. He has seen his physician and is in excellent health, "So the doctor said I should talk to you." Then, bluntly at the end of the session, "Do you think you can help me be a man again, or am I too old?"

Data Case I

Summary views of the data are that Howard's sexual difficulties are a result of his depression, with recognition that depression may be secondary to sexual failures. While enthusiastic in their optimism about Howard's sexual future (not one felt the prognosis to be poor), according to group opinion, Howard needs primarily to examine in depth his passivity toward women rather than direct help with his sexual symptom. Twenty clinicians believed help for Howard's sexual disorders need not await attention to these other issues, yet only five indicated immediate help to be required. Hapless Howard.

Delineated opinions about Howard, when ranked, show agreement in descending order as listed in Table 7 below. In formulating treatment approaches, likelihood, indecision and unlikelihood is ranked in Table 8, following. Howard as seen in this analysis, would most likely be offered some direct sex information and counseling and be involved in further exploration of personal history. Long-term psychotherapy is less probable, but still possible plan for him. There is some likelihood that he'll be offered an individual program in sex therapy, but an equal chance (one in four), that he'll be helped to "accept" his aging,[45] or provided with short-term

work re: social skills. Almost no one would look for or help Howard look for a partner for sex therapy, but he has about a 20% chance of being referred elsewhere to a sex therapist. In this sample, none was inclined to explore medication as a solution for Howard's problem.

TABLE 7#

ASSESSMENT CASE I

Assessment	Agree	Disagree
Howard is experiencing sexual difficulties as a symptom of depression.	82%	18%
Howard is experiencing depression as a result of his sexual dysfunction and lowered self-esteem.	76%	24%
Howard, as a means of improving his sexual functioning, needs to examine in depth his passivity with women.	58%	42%
Given Howard's age and life style, prognosis for his regaining sexual functioning is poor.	0%	100%
Howard requires immediate help with his erectile problems before other issues should be addressed.	15%	85%
Howard's erectile problems cannot be helped until he resolves other issues.	42%	58%

*Appendix B, p.207, items #1-6.

TABLE 8*

TREATMENT APPROACH, CASE I

Treatment Approach:	Likely	Undecided	Unlikely
Provide Howard with sexual education and counseling (e.g., information regarding alcohol's effects, performance anxiety, etc.)?	73%	6%	21%
Explore Howard's developmental history in depth to clarify where the pathology lies?	61%	9%	29%
Help Howard accept his need for long-term therapy to work through his psychological conflicts?	32%	47%	21%
Offer Howard an individual program in directed sex therapy with assignments (e.g., self-stimulation, reading, etc.)?	26%	21%	52%
Help Howard accept the inevitable sexual changes of aging and work through his feelings of loss?	26%	6%	67%
Work with Howard on a short-term basis, helping him acquire new social skills (assertion training, leisure time pursuits, communication)?	23%	26%	50%
Refer Howard to sex therapist?	21%	32%	47%
Involving Howard and his partner in sex therapy with a male-female co-therapy team	12%	21%	67%
Consider with Howard seeking a female partner for directed sex therapy?	9%	15%	76%
Consider with Howard your providing a female surrogate?	3%	12%	85%
Refer Howard to his physician for medication in addition to psychotherapy?	0%	15%	76%

*Ibid, items #1-11, p. 208.

There is no evidence that Howard would receive markedly different treatment regardless of what type (cluster group) therapist he encountered, although with the Contemporaries (who include sex therapy) he's more likely to be offered some form of direct help for his sexual complaint. As a group, the social work/sex therapists are less opposed to considering an experience with a partner. His chances for referral to a sex therapist are, of course, greater if he isn't seen by someone who so designates him or herself. Yet of seven who might refer, two respondents, inexplicably, are among these who deem themselves as including sex therapy in practice. A further contradiction is the high proportion of those who, although stating they do not include sex education or counseling in their practice (Conservative/Traditional cluster), do, in fact, consider it a likely plan were Howard their client.

Other possible plans for Howard were advanced by survey participants (e.g., to work further in the area of his grief or other feelings about his marriage and/or his fear of failure with women). These seem to the author to be elaborations subsumed in other choices provided. However, they were the special emphasis of some respondents. No one proposed more direct intervention.

Summary Case I

The treatment of sexual disorders in individual clients presenting no willing partner poses particular challenges in therapy. Beyond the uniform requirement to discern etiological features and form adequate treatment plans, are the practical difficulties of the single social scene. A brief sketch of Howard's life elicited clinical plans emphasizing further psychotherapy, with some sex counseling or education. Responses shied away from many direct procedures commonly used in sex therapy with such cases.

Howard was manifesting, indeed, classic performance anxiety and surely some of his depression was attendant upon his sexual failures; poor social skills as a "new" single were also evident. To withhold immediate sexual help for Howard, while exploring psychic issues, including his passivity with women, could exacerbate Howard's increasing fear of intimacy with women and/or discourage him from any future therapeutic process. To "help him accept the inevitability of aging" would seem a mediocre goal for this robust and recently sexually potent man; certainly it was not his goal.

To assume that treating his mild depression would counteract his severe sexual symptom raises the

question of who controls treatment, client or worker. Howard was clear about his ailment, i.e., situational impotence, and the resulting emotional upset he was experiencing. Accumulated evidence shows that this type of dysfunction and performance anxiety compounds quickly and not infrequently results in chronic impotence. As with school refusal (or phobia), it is important to interrupt the cycle of defeat, fear and self-fulfilling prophecy as rapidly as possible. The professional who presumes to know better than the client what "ails" him may be doing a disservice to both.

Material for the second case (Case II) follows as presented to the respondents:[46]

Referral source: Local mental health agency.

Presenting request by telephone: "Personal and marital problems."

Presenting complaint: Depression and anxiety re sexual apathy.

Lena, a 22-year-old-woman, in the first session at times weeps because her marriage is failing and she blames herself. She and her husband, Kent, have a good relationship after four years of marriage. He just got a better job, they have purchased their first home and will have more space for themselves and the two children, ages one and three. Everything "should" be beautiful, but she is depressed, fatigued, tearful daily, feels "rotten" (guilty) constantly about her sexual apathy and the disappointment she senses in her husband. He is quiet, doesn't complain, but she knows every night when he looks at her "that way" that he is thinking about how things used to be between them

sexually (before and after their marriage) up until about two years ago.

Even now, in those rare instances when she can accommodate his wishes, she achieves orgasm readily, but sex seems like a chore, a duty. She is afraid he will leave her, although he probably won't divorce her because they are both strict Catholics. In fact, sometimes she thinks she should have been a nun since she feels as she does about sex. It's funny, but she was just really beginning to relax and enjoy sex after their marriage and the first baby, when her attitude began to change. Now she can hardly bear for Kent to hug her; they're both miserable and it's her fault.

Kent wants to help her but she doesn't know what to ask him to do. She has talked with no one as she is shy and doesn't have any friends since she left her job. Lena couldn't talk to her mother because of her mother's "negative attitude" toward men and sex because of the troubles with Lena's father.

She is home alone with the children and the problem is on her mind; maybe she should get a job and try to forget it. If she is going to need a lot of professional help, money will be a big problem anyway.

Data Case II

Statements about Lena and her sexual apathy were assessed, as in Table 9. The composite view is that Lena's sexual apathy is secondary to her depression and isolation; with cultural-religious factors, developmental experiences, and lowered self-esteem figuring as further causal factors. Lonesome Lena.

Less consensus obtains regarding the role of interpersonal or marital strains although most felt prognosis was good. Only a quarter would address the

sexual concerns initially. The Conservative/Traditional group were unanimously opposed; the Contemporaries showed less agreement with that position than other clusters, but not with any true unanimity.

TABLE 9*

ASSESSMENT, CASE II

Assessment	Agree	Disagree
Given Lena's age, relationships and background, the prognosis is good.	91%	9%
Lena's depression and guilt are a result of lowered self-esteem.	85%	15%
Lena's symptoms are a reflection of her developmental experiences with clues of her parents' dissatisfactions.	85%	15%
Lena is reacting to cultural-religious training and a conflict re: sexual pleasure.	79%	21%
Lena's sexual apathy is a result of her depression and isolation.	73%	26%
Lena's sexual symptoms are an expression of interpersonal strains between herself and Kent.	58%	42%
Lena's sexual concern requires immediate help before other issues should be addressed.	26%	73%

*Appendix B, p.210, items #1-7.

Likely treatment plans ranked (in order of greatest acceptance) for Lena are:

TABLE 10*

TREATMENT APPROACH, CASE II

Treatment Approach:	Likely	Undecided	Unlikely
Work with Lena on a short-term basis toward improving her immediate situation to decrease her isolation, increase the communication with Kent.	64%	21%	15%
See Lena and Kent, as a couple, exploring their interpersonal relationship in general.	55%	35%	9%
Work with Lena on a long-term basis toward alleviating depression, exploring intrapsychic issues.	38%	50%	12%
See Lena and Kent, as a couple, exploring with a co-therapist of the opposite sex, their interpersonal relationship in general.	18%	55%	47%
Offer Lena an individual program of directed sex therapy assignments.	15%	29%	55%
Proceed with the couple in time-limited, directed sex therapy, including pleasuring assignments; sexual materials, etc., working with a co-therapist of the opposite sex.	12%	26%	61%
Refer Lena and Kent elsewhere for sex therapy.	9%	29%	61%
Proceed with the couple in time-limited, directed sex therapy, including pleasuring assignments, sexual materials, etc.	9%	29%	61%
Refer Lena elsewhere for sex therapy.	9%	26%	64%

*Ibid, items #1-9, p. 211.

In summary, Lena is likely to be seen in short-term work, with a good chance that she and Kent may be seen as a couple with a focus on the general relationship. While, as noted above, no majority agrees upon other plans, a proportion of "undecideds" leave room for these other possibilities in the future.

Least likely would be any of the several plans for sex therapy. Consistent with the sample's view that the presenting sexual complaint does not require immediate attention, the greatest likelihood is that Lena would be offered individual work, focused away from the sexual complaint, presumably with the hope that indirectly this would restore sexual appetite and function. Perhaps, with tongue-in-cheek, the 38% who would prefer long-term work were seeing indirect benefits for themselves as well as the client in Lena's return to work as a method of decreasing her isolation and financing her therapy.

Subgroup analysis reveals, in addition to the comments above, several plans had no support from the Conservative group and little from the Traditional. These plans involve either co-therapy, directed sex therapy or referral. One Traditional respondent would apparently refer for sex therapy and two would explore the couple's general relationship with a co-therapist of the opposite sex. Plans to see Kent and Lena as a couple were more

clearly favored by the Contemporaries (either with or without a co-therapist). As a group, however, the Contemporaries lacked consensus about employing any of the several definite approaches to the sexual concerns, in spite of having, in some instances, declared themselves as agreeing that her sexual concern requires immediate help before other issues are addressed.

Summary Case II

Lena's case is one where any of several approaches offers hope, but in terms of what clinical social workers do with such cases, one concludes they don't deal directly, early in the case, if at all, with sexual complaints. There appears to be support for the notion that intrapsychic or marital harmony will insure sexual functioning with no need to deal with that sexual "symptom." It is abundantly clear that Lena's sexual problem would not be addressed very readily regardless of what group her therapist resembled (although she tells the social worker that is the central theme of her misery).

Alternative plans or comments from the questionnaires stressed a wish to clarify whether Lena's struggle was intra- or interpsychic in nature, and/or to explore the precipitating events more fully, e.g., "Why now?" "What happened when sex stopped being fun?" These are,

of course, valid questions, again echoing the clinician's wish for more information with which to make judgments, and perhaps the basis for some "undecided" responses. There were no comments endorsing more direct intervention in sexual matters.

The third case (Case III) was summarized for consideration as follows:[47]

Referral source: Attorney-friend (former client).

Presenting telephone complaint: Marital crisis and personal distress.

Presenting complaint in session: Acute anxiety, irritability, emotionally labile in connection with possible loss of marriage.

Stan, age 38, is frantic and self-condemning over the threat of separation by his 25-year-old wife, Julie, a part-time psychology student. She has revealed a two-year affair with a prominent physician; both are considering divorcing in order to marry. Julie will remain "awhile" for the sake of the children, ages three and five, if Stan can "become responsive to her emotional needs."

Stan gives a history highlighted by the onset of a chronic disease in his late adolescence and the "loss" of a decade as he was partly incapacitated, withdrawn and depressed. Ultimately, the disease has been controlled through medication and while there is a minor disability and some pain, he functions well in his work as an accountant, building up his business, pushing himself for Julie and the boys.

Over the past 10-15 years he has occasionally considered the idea of psychotherapy, but it seemed a luxury; now he wants very much to understand himself better, his lack of friends, compulsion for work, and how to be a better husband and father. Before Julie confronted him, he thought everything was fine; he knew she had been talking with a counselor but assumed it was a part of her studies.

Now he knows how wrong he was; he wonders why he had been so blind; he sobs briefly. He is having trouble with mood swings and lack of concentration. Julie reports her female counselor advises against marital work and for now she declines permission for contact with the counselor. Stan wants to work with you regardless.

As your work proceeds Stan regains control at his office, begins to recognize his anger at Julie's secret affair and makes some association to events in a period of his illness. You feel the work is progressing well.

In the ninth session, Stan reports a recent argument (until now the couple has rarely disagreed openly) in which he demanded Julie stop seeing her lover. Julie retorted that Stan had "never satisfied" her sexually, he's never "lasted long enough" or been interested "frequently enough" and her counselor said he ought to see a sex therapist. He is hurt, surprised and very threatened by this, since he had believed their sexual adjustment was one of the positives throughout the marriage. He is, however, willing to try to please Julie. He asks your recommendation about sex therapy since he's long had worries about his "vigor."

Data Case III

There is agreement about Stan in the data in Table 11. This client was regarded with uncertainty in several ways as demonstrated in this table. There is less consensus about cause and nature of the sexual disorder; the treatment picture is further complicated because of severe marital problems and the ambiguity of an elusive spouse's contributions. One must deliberate whether the focus of treatment can best remain with the individual or be shifted to the couple, whether the sexual complaint is his or hers, whether organic factors may be involved, and what is the import of the therapy already in process.

TABLE 11*

ASSESSMENT, CASE III

Assessment	Agree	Undecided	Disagree
There is a question about the nature of Stan's disorder.	97%	3%	0%
The sexual problems cannot be helped in all probability until Stan and Julie resolve other marital conflicts.	53%	3%	44%
Stan's sexual difficulties are due to a recurrence of depression and anxiety associated with major loss.	47%	3%	50%
Stan's sexual difficulties are attributable to his physical disease and/or medication.	29%	15%	56%
Stan's sexual concerns are more a reflection of Julie's anger than his dysfunction.	45%	3%	56%
The sexual problems cannot be helped in all probability until Stan resolves other intrapsychic conflicts.	38%	3%	59%
Stan needs immediate help with his sexual complaints before continuing with other therapy.	23%	3%	74%
The sexual concerns cannot be dealt with in the absence of Julie's participation in the sex therapy.	18%	0%	82%
Prognosis for improved sexual functioning is poor.	3%	3%	94%

*Appendix B, p.213, items #1-9.

These factors and perhaps other may account for the less decisive responses and the reluctance of the sample to

accept a forced answer in agreement or disagreement about Stan. Nonetheless, with therapeutic optimism (informed or otherwise), the group does not see a poor prognosis for his improved sexual functioning; improvement over what is unclear.

The sexual difficulties are not regarded by these respondents as reflections of either Julie's anger or Stan's physical illness. Help for the sexual concerns is not contingent upon Julie's participation nor Stan's resolution of other intrapsychic issues. Only 24% would agree that Stan needs immediate help with his sexual complaints (although advice about such help is certainly his urgent verbalized request; presumably, effective treatment would not consist of ignoring his inquiry). What the majority 53% (N=18) does hold is the notion that help with sexual problems depends on resolution of marital difficulties. Such an impression may not, however, underlie the selection of certain treatment choices shown herein, (Table 11, above) with any constancy.

The most likely plan, to "clarify with Stan his historical and present sexual experiences to determine what dysfunction exists" seems consistent with the uncertainty about the nature of the complaint.[48] Next most likely, somewhat surprisingly, is to refer Stan

elsewhere for sex therapy while continuing primary therapy. The least likely choices were to interrupt current work and offer a directed individual program in sex therapy which had no proponents. A similar interruption for sex counseling and education was unlikely in the judgment of 76%. Suggesting the use of a surrogate partner for Stan in sex therapy if Julie is unwilling was favored by only one person.

A full 73% would not advise against sex therapy, even on the basis that, without Julie's full cooperation, marital stress would interfere with such treatment. Since 53% of these same respondents saw help with sexual problems contingent upon marital issues, it seems inconsistent that in those items requiring or offering an opportunity for the social worker to "take a stand," the thrust is for Stan to proceed with sex therapy, but elsewhere. Response which allows postponement of the matter of sex therapy, evidences an almost perfect reflection of the sample's indecision (N=11 vs N=11 with N=12 undecided).

In those plans which attempt to involve Julie in marital and/or sexual counseling, there is little consensus, presumably because the case description conveys a tone of inaccessibility on Julie's part which some accept as final, while others persist in urging Stan to gain her

cooperation in the face of her reported refusals.

TABLE 12*

TREATMENT APPROACH, CASE III

Treatment Approach:	Likely	Undecided	Unlikely
Clarify with Stan his historical and present sexual experiences to determine what dysfunction exists?	97%	3%	0%
Continue working as you have been with Stan and refer him elsewhere for sex therapy concomitantly?	44%	29%	26%
Urge Stan to gain Julie's co-operation in marital therapy?	41%	23%	35%
Attempt to work out a plan for Julie and Stan in co-therapy (involving Julie's counselor or other professional) toward resolving their marital issues?	38%	26%	35%
Continue working as you have been with Stan through insight and awareness, postponing any sex therapy?	32%	35%	32%
Urge Stan to gain Julie's cooperation in sexual therapy?	32%	32%	35%
Set aside your ongoing work and focus on sex counseling education; teach Stan techniques for prolonging intercourse and provide information on female sexuality?	12%	12%	76%
Advise against sex therapy for Stan because of lack of cooperation by Julie; strains between them will interfere with such treatment?	6%	21%	73%
Suggest the use of a surrogate partner for Stan in sex therapy if Julie is unwilling?	3%	15%	82%
Interrupt your current work with Stan and offer a directed program in sex therapy for him individually?	0%	15%	85%

*Appendix B, p. 214.

The majority's recommended plan for Stan would be to gain clarification about the sexual experience, with the likelihood of continuing in some manner with the primary therapy, probably being referred elsewhere for sex therapy, and with a chance that he and his wife be urged toward some type of therapy together. That his primary therapist will work with him individually in sex education, counseling or therapy is a negligible possibility. Stalwart Stan.

In terms of subgroup reactions, the most evident contrast, not unexpected in one sense, is shown by the fact that the Contemporaries (who practice sex therapy) would not refer Stan to a sex therapist while continuing the primary therapy. The Conservative/Traditionalists would highly favor that very plan. As indicated elsewhere, such a referral might well be premature. Nor would the latter (Conservative/Traditionalists) advise against sex therapy, while the Contemporaries are more confident about that very recommendation. It appears those least familiar with sex therapy, could in this case, be in the vanguard of referral.

Summary Case III

As alluded to above, sexual factors combined with relationship issues present especially thorny treatment problems at this stage of knowledge. Stan's case

illustrates several of these. It is the author's conviction that the request for sex therapy arising during a course of treatment should be examined both for its own merit and as it may pertain to other phases of treatment. Stan's successful engagement in individual therapy argues to a degree for continuing that very process. Julie's stance, if accurately portrayed, does not augur well for conjoint work in either marital or sexual therapy, since her attitude is that Stan is the person needing to change, emotionally and sexually.

An additionally distinguishing feature of this case is that the complaint about sexual disorder came not from the client but from an absent partner. While Stan was overwilling to accept responsibility, it was unclear wherein the request for sex therapy arose--with Julie, her counselor or Stan? Put another way, it is risky to accept a second or thirdhand description of sexual (or other) behavior when such reports may well be biased and/or define one person's "dysfunction" (Stan's) by the calipers of another's (Julie's) dissatisfaction.

It is not infrequent, of course, that a therapist hears a complaint from one spouse about the other, or that one member of the relationship is sexually or otherwise dissatisfied to the surprise of the other. There is, however, always need to clarify individual and mutual

experience, goals or hidden motives before accepting the view of one person about another. The author would routinely hesitate to define one person's sexual capacity or performance in terms of secondhand information or complaints. Stan's initial inquiry was not couched in terms of his awareness, dissatisfaction or even clarity about Julie's feelings. He indicated only that he unquestioningly would do whatever was required to please her. Worry about his "vigor" was, of course, a generalized concern not uncommon with older men and younger women, or with a man who has had substantial health problems, but not universally an indication for intervention.

Referral for sex therapy, cessation or alteration, although temporary, of the direction of primary therapy, recommendation for a surrogate partner, etc., all have implications of the social worker tacitly agreeing that a sexual disorder exists which does indeed require specialized therapy. Had a therapist, (misled by the request, disquieted by unfamiliarity with sex therapy), suspended or deviated in personal therapy, made a referral either for sex therapy or work with a surrogate, the consequences might well have been negative. First, such a referral might well have served as a confirmation of Stan's vague fears and new anxiety about his sexual performance. Second, the potential deflection or

interruption of the ongoing therapy process at that point might have precluded Stan's own insightful progress.

Efforts to involve Julie had been rebuffed by her on several occasions, and expecting Stan to urge conjoint therapy offered little additional hope but may well have strained Stan's labile circumstances. Given his emotional upheaval with his wife, it is doubtful he would have benefitted from or consented to for help from a surrogate. In effect, the question of sexual treatment was best determined by probing clarification with Stan, as was the sample's first choice.

Summary of Case Findings

The spread of case plans is indicative of variation in individual perception and anticipated bias. Nevertheless, a tendency to appraise sexual disorders as inevitably secondary to other problems is evident in the first two cases. In the third case, an almost superficial willingness to accept a need for sex therapy is noted, yet ultimate resolution of sexual complaints is seen as a function of marital issues.

Based on these data, Hypotheses XIV and XV are supported. Clinical social workers hold to the position that sexual problems are indicative of other pathology. They engage

in little direct treatment of such disorders and are ambivalent about such treatment when requested, or precipitately responsive. Subgroup analysis supports Hypothesis XIII with the inconsistency of cluster patterns as compared with case assessment and treatment plans as seen above. The case vignettes produced, as anticipated, more flexibility and even less rigorous consistency of practice mode and theory. Those clinical social workers without exposure to sexual education or specific training were often as open to different approaches as were their peers with specific sex educational backgrounds.

FOOTNOTES

CHAPTER IV

[1]Appendix B, pp. 205 ff., contains a sample of the survey instrument as self-administered by respondents.

[2]The distinctive term "training," implying (to most social workers) work under supervision, was included in the inquiry about sex therapy. The author is dubious as to whether it was read carefully in that light. But, as independent professionals, social workers monitor their own areas of preparation and competence beyond the minimums for licensure. See Appendix B, p. 13.

[3]No legal requirement can insure true learning nor changes in practice. Yet it appears that Assemblyman John Vasconcellos, together with the California State Legislature, may have been correct in suspecting that a fair number of clinical license holders have not been exposed to any educational experience in this part of human life about which new information is emerging.

[4]Presumably, although not always clearly identified, the authors and works intended by the respondents were: (1) Helen S. Kaplan, The New Sex Therapy, (New York: Brunner/Mazel, 1974); (2) William H. Masters and Virginia E. Johnson, Human Sexual Response, (Boston: Little Brown and Co., 1966) and/or Human Sexual Inadequacy, (Boston: Little Brown and Co., 1970); and (3) Alex Comfort, ed., The Joy of Sex, (New York: Crown Publishers, Inc., 1972). Appendix B, p.221.

[5]Schultz, op. cit.

[6]Len and Fischer, op. cit.

[7]As indicated in 4 above.

[8]Appendix B, p. 216.

[9]Ibid.

[10]Ibid, p. 218.

[11]Ibid, p. 217.

[12]Ibid.

[13]Ibid, p. 218.

[14]Ibid, p. 217.

[15]Ibid, p. 218.

[16]Ibid.

[17]Ibid.

[18]Ibid, p. 217.

[19]Ibid, p. 216.

[20]Ibid, p. 216-217.

[21]Ibid, p. 217.

[22]Ibid.

[23]Ibid.

[24]Ibid.

[25]Ibid, p. 216.

[26]Ibid, p. 217.

[27]Ibid, p. 218.

[28]Ibid, p. 217.

[29]Ibid, p. 218.

[30]Ibid, p. 217.

[31]Ibid, p. 216.

[32]Ibid, p. 216.

[33]Ibid, p. 217.

[34]Ibid, p. 216.

[35]Ibid, p. 218.

[36]Ibid, p. 217.

[37]Ibid.

[38]Ibid, (Schultz noted a 45.6% usage rate for teaching masturbation in his 1977 study, with 66.7% approving the technique; see Schultz, op. cit., p. 94.)

[39]Ibid, p. 216.

[40]Ibid, p. 218.

[41]Len and Fischer, op. cit., p. 46.

[42]Schultz, op. cit., p. 94.

[43]Ibid.

[44]Appendix B, p. 206.

[45]This was a rare instance of a clear difference between male and female respondents; 80% of the males opposed helping the client accept "inevitable changes," while only 62.5% of the women rejected that plan. Appensix B, p. 208.

[46]Appendix B, p. 209.

[47]Ibid, p. 212.

[48]Ibid, p. 214.

CHAPTER V

CONCLUSIONS

The purpose of this study has been to inspect views held by clinical social workers as regards sex therapy, counseling, education and sexual complaints on the part of their clients. The analysis of this professional sample supports the view that sexual "blinders" are coming off (i.e., a large number of these social workers have undertaken some education experiences); 74% have read in the field and another 74% have had courses or workshops at some point in their careers. Only a minority of 15% have had neither exposure.

Disparities, education/practice gaps and lags are apparent in at least two dimensions. First, of that portion of the sample who identify sexual counseling, education and/or therapy as part of their practices, 13% have no formal instruction, relying only on their (scant or ample) readings. Second, of those who have some formal educational preparation, approximately 33% disclaim using their learning in practice.[1] Combined figures suggest a fairly high figure, 29% of the sample, of practitioners somehow discordant in their preparation and/or usage of these skills and techniques in practice.

Most respondents who have had some courses or workshops

in general human sexuality find these helpful in their work. A majority include sex education and counseling in their practice, and they own some materials (books, charts, etc.) which they use with clients. The majority of members had not, however, met the BBSE relicensure requirements by March 1979, suggesting that courses undertaken had been either prior to 1970, or with content or auspices which did not qualify, or otherwise failed to meet the required minimum ten hours.

In brief, the "typical" respondent (demographically described above in Section C) accepts sex therapy as a part of clinical social work, is not opposed to its inclusion in practice on any (herein) discernible theoretic grounds, is somewhat knowledgeable about its content, sees some relationship to psychodynamic principles, and, while leery of direct therapeutic interventions, is willing to offer counsel or education, but is ambivalently committed and minimally prepared. Other firm convictions are absent. This is in fact a profile of the preponderant Conventional subgroup.

The minorities at either extreme distinguish themselves only slightly from this profile. Contemporaries, i.e., those practicing sex therapy, are clear that required emphasis on behavior modification and direction of clients is not a basis for exclusion of sex therapy from

practice. They are certain that sensate focus does not mean orgasmic stimulation; they agree with the possible benefits of nonerotic contact (if acceptable to the client), show a unanimous preference for treating couples where relationship issues are crucial to sexual problems, are willing to teach about masturbation, clearly recognize the importance of client history in sex therapy, and are certain that these treatment techniques are becoming a standard part of clinical social work. They are exceptionally strong in declaring their lack of greater or lesser comfort in all instances, except with homosexual clients as opposed to heterosexual, and are heartily convinced that sex therapy may be the treatment of choice even in the presence of overt psychopathology.

The Conservative/Traditional groups stand out also in their intellectual recognition of the incorrect description of sensate focus. These respondents are solidly convinced of the efficacy of time-limited therapy, absolute in their refusal to instruct about masturbation, share the Contemporaries' belief that sex therapy may be treatment of choice even in presence of overt psychopathology, and accept as its goal the removal of obstacles to sexual functioning. They are not united in opposition to behavioral approaches. They differ among themselves markedly only on the issue of the future in

social work. As noted elsewhere the Conservatives do not see these techniques as becoming a standard part, while the Traditionalists do. Since neither group saw this interest as a fad, one might conclude that in some minds sex therapy is here to stay, but not as part of social work.

The data suggest that sex therapy is not accepted or rejected on the basis of any clear theoretic or modality issues. There is, in most instances, remarkably little rigidity or clear cleavage among sub-groups. Whether such findings are evidence of open minds, healthy flexibility or absence of conviction or thoroughness is difficult to say. However, the degree of inconsistency in some areas supports the notion that this clinical group is without clear perspective or well-thought-out postures as regards treatment of sexual problems.

While tolerance for variation and pluralism is healthy, the lack of consensus is somewhat disquieting, suggesting that those who use sex therapy approaches may not have thoroughly considered various issues, while others may be ignoring new findings and modes of service. Most, while somewhat open to concepts of sex therapy, evidence little interest in intensive or extensive preparation. Nor do the groups' experiences in education and/or

training, except infrequently, relate to their expressions of agreement or disagreement with general ideas or specific modes. One would expect, for example, the Contemporaries to be more certain about legal requirements, to show more uniformity about goals, to display greater willingness to inquire of clients, and to have set to rest any doubts about "symptom relief," none of which is the case. Their view of cases is not markedly dissimilar from that of the other clusters.

Conversely, one could have expected the Conservative/Traditional group to have expressed more solid conviction about sexual dysfunction as symptoms of psychopathology, and greater dubiousness about "symptom relief," as well as more disdain for behavior modification and directing of clients; this is not so. Their treatment of case material points up that they do indeed offer services akin to sex education and counseling in some instances and may refer for sex therapy in spite of their generally stated disclaimers.

The examination of the sample confirms that, for the past several decades, the graduate social work curricula had rarely included general courses in sexuality. Only two respondents indicate participation in such courses either as a part of graduate or undergraduate education: One (MSW 1955) reported a required course; one (MSW 1962), an elective. Further, there is indication that when social workers

have undertaken some course work, the educational experiences were insufficient for them to feel adequate in treatment techniques. Relatively few have sought actual training programs under any auspices; where such programs have been utilized they often lacked social work sponsorship, tending, as well as can be ascertained, to be heavily medically influenced.

While not denying the important of Masters'-Johnson's work, or the need for awareness of organic features and physical components, the profession of social work may have suffered from undue medical influence, and a lack of social work models in the sexual field. This has led to or increased the assumption that "others" are better qualified (not an unusual tendency in social work in general) and possibly has enhanced the view of sex therapy as mechanistic or narrowly behavioristic. The opportunity to examine sex therapy as an integral part of or adjunct to clinical social work and psychotherapy has been diminished or nonexistent. Conversely, the consideration of the contributions which social work can make to the theory and practice of sex therapy has not been fully or widely comprehended. Social work has been hesitant (or shy?) in declaring, even where extant, its interest or expertise in this field.

Further, clinical social work's identification with the

traditional psychoanalytic profession and processes has caused an overemphasis on the view of sexual problems as being inevitably expressions of other psychopathology. Issues of psychosomatic symptomatology and treatment also underlie this controversy. The lack of attention to or interest in a major theme in life is troublesome as it pertains to the profession's need to clarify issues and choices. In 1976, Masters and Johnson reiterated: "We as professionals must be aware of how inadequate our primary disciplinary training has been in equipping us to meet the public's legitimate demands." They note also the strength of the "newest health care discipline" deriving from the "multiplicity of professions" directly involved.[2]

Clinical social work is doubtless a profession alluded to as one whose primary training has not supplied its members, adequately, in the past; the present and the future need not perpetuate this deficiency. Jackson's work confirms that clinical social workers are self-identified as psychotherapists committed to values of individual and societal betterment focused in the "interaction of the biological and social aspects . . . ."[3] The latter phrase surely describes much of the content of the previous discussion in the development and/or treatment of an individual's sexuality with functional or dysfunctional attributes.

In this area of human discontent no single style or conviction prevails as to the role of the clinical social worker (or any psychotherapist). Some authorities would argue that primary psychotherapy is contaminated if sexual performance issues are the focus; others feel the sexual therapy is ineffective when distracted by other psychotherapeutic issues. Further investigation is required before either position can be endorsed as correct.

This present study indicates the lack of consensus in the formulation of likely treatment plans (as illustrated in three case vignettes), and unevenness or paucity of formal education and preparation (as shown in demographic data), and a lack of clarity around components of sexual therapy and the integration in psychotherapeutic practice (as revealed in general data). By extrapolation, the entire clinical social work profession has yet either to solidify relevant positions or to incorporate these. Jackson's study also speaks of respect for theoretic pluralism among clinical social workers, with a preference for psychoanalytic theory and practice "blending with existential growth theory."[4] The blend, apparently, is indeed, a widely varying mix, related to complex factors, especially when applied to sexual problems of clients.

Studies herein cited by Len, Fischer, and Schultz point to similar conclusions. While thousands of therapists, including unknown numbers of social workers, are now engaged in treatment of sexual dysfunction, the profession has yet to develop clarity as to educational and practice standards. Those above-mentioned clinicians urge, as does this writer, clarification of values through research as the basis for giving or withholding endorsement of treatment techniques. Major among these are matters of appropriate therapeutic clinical social work tasks, roles, the results of special education or training and the efficacy of integration into practice. Hollowitz and Shore[5] identify the aim in teaching human sexuality as ". . . to develop competent professionals who, in the course of working with individuals, couples, and groups, will be able to assess and treat sexual functioning just as . . . other aspects of human function." It is a moot point as to whether current courses (required, elective or remedial) share that aim since it appears that our profession has not fully examined the implications or underlying values sufficiently to embrace that notion or to offer guidelines for its students or practitioners.

One can only speculate as to the probable findings in a broader or different sample of master's level social workers.

In the author's estimation such a group would likely include a higher proportion of social workers educated in the 1970's and hence would bear more resemblance to the Contemporaries of this sample, that is, more social workers inclined to include sex therapy. On the other hand, since this present sample is unusually committed to advanced education, one might encounter in a wider sample a less well-informed group. Recent de-emphasis of casework in many graduate schools might produce findings of even further diminution of clarity or consistency with theoretic or case analysis. Further research comparisons would, of course, be desirable.

The clinical group shares social work's history and values involving social welfare concerns. Sexual issues, if not clinical problems, are omnipresent in the many settings in which social workers serve, not only in treatment, but in programs and policy considerations as well. Broad social and political forces, beyond this paper, involving sexuality and social work clientele are thrust upon the profession, requiring professional and personal wisdom. The choice is not whether these issues will be dealt with, but how, when, and by whom they will be addressed. Clinical social work has much to contribute directly and indirectly to present or future solutions in its rich understanding of society and aspects of psychosexual development.

Professional services provided by clinical social workers can be improved as the profession further selects and incorporates new findings and experience from this field. Differences are of course anticipated and desirable. These compel exploration to preclude decisions or judgments made through positions of default. The present study suggests the time is now, the need urgent.

"We cannot give up the search for the solutions to people's problems," writes Schultz in inviting further research.[6] The author adds her voice to those encouraging further, prompt, and thorough examination of these matters. The goal is to move toward resolution of major professional issues which impair the integration into the profession of clinical social work consideration of all aspects of life. This goal would include examining what may be the appropriate, efficacious treatment of disturbances in sexuality.

FOOTNOTES

CHAPTER V

[1]Since no inquiry about current work assignment was included, it is possible that some respondents are primarily employed in situations where direct treatment issues are nonexistent or minimal. (For example, one respondent of the Traditional group marked the practice survey question as "not applicable.")

[2]William E. Masters and Virginia Johnson, "An Interdisciplinary Approach to Sexuality," Personnel and Guidance Journal, LIV (1976), 368.

[3]Jackson, op. cit., p. 82.

[4]Ibid.

[5]Emanuel Hollowitz and David Shore, "Teaching Human Sexuality," Health and Social Work, III (November, 1978), 133.

[6]LeRoy G. Schultz, "Ethical Issues in Treating Sexual Dysfunctions," Social Work, XX (March, 1975), 128.

BIBLIOGRAPHY

"About the Authors." Clinical Social Work Journal. Vol. I, 1973, No. 4.

Adelson, Edward, ed., Sexuality and Psychoanalysis. New York: Brunner/Mazel, 1975.

Alger, Ian. "Discussion of Helen S. Kaplan's Sex Therapy: An Overview," Sexuality and Psychoanalysis. New York: Brunner/Mazel, 1975.

Annon, Jack S. The Behavioral Treatment of Sexual Problems. I and II, Hawaii: Enabling Systems, 1974.

Apfelbaum, Bernard. "On the Etiology of Sexual Dysfunction," Journal of Sex and Marital Therapy. II, 1976, 50-62.

"The AASECT Affair," Sexuality Today. II, June 18, 1979, 3.

Axe, A.F., "Editorial," Psychophysiology." Vol. I, 1964.

Bidgood, Frederick. "Human Sexuality in the Social Work Curriculum," Sex Information and Education Council of U. S. Report. I, November, 1972, 6.

Brashear, Diane. The Social Worker as Sex Educator. Sex Information and Education Council of the United States. New York: Human Sciences, 1976, 4.

Bruni, Ernest. "Psychotherapists as Sex Therapists," Psychotherapy, Theory, Research and Practice. Vol. XI, Fall, 1974.

Bullough, Vern L. "Sex and the Medical Model," Journal of Sex Research. II, November, 1975, 301.

California Administrative Code. Title 16, Chapter 18, Section 1878.

California Statutes, 1976, Chapter 1433.

California Statutes, 1978, Chapter 92.

Carrera, Michael and Rosenburg, Gary "Inservice Education in Human Sexuality for Social Work Practitioners," Clinical Social Work Journal. I, 1973. No. 4, 261-2.

Comfort, Alex. ed., The Joy of Sex. New York: Crown Publishers, Inc., 1972.

Cook, Mark and McHenry, Robert. Sexual Attraction. New York: Pergamon Press, 1978.

Davis, Katherine. Factors in the Sex Lives of 2200 Women. New York: Harper Row, 1929.

Diagnostic and Statistical Manual of Mental Disorders. 3d ed. American Psychiatric Association. Washington, D. C., 1980.

Ellis, Albert. Humanistic Psychotherapy: The National Emotive Appraoch. New York: Julian Press, 1973.

Erikson, Erik. Identity: Youth and Crisis. New York: Norton, 1968.

Fischer, Joel and Gochros, Harvey. eds., Handbook of Behavior Therapy. New York: Pergamon Press, 1979.

Fordney-Settlage, Diane S. "Heterosexual Dysfunction: Evaluation of Treatment Procedures," New Directions in Sex Research. E. Rubenstein, R. Green and E. Brecher, eds., New York: Plenum Press, 1975.

Gadpaille, Warren. The Cycles of Sex. New York: Charles Schribner and Son, 1975.

Gochros, Harvey L. "Human Sexuality," The Encyclopedia of Social Work. Washington, D.C.: National Association of Social Workers, 1977, 686-696.

_____. "The Sexually Oppressed," Social Work, XVII, 1972, 16.

_____. "Sexual Problems in Social Work Practice," Social Work, XVI, 1971, No. 1, 3.

_____. and Schultz, LeRoy, eds., "Social Work's Sexual Blinders," Human Sexuality and Social Work, New York: Association Press, 1972, 85.

Gottesfeld, Mary L. "The Editors Introduction," Clinical Social Work Journal, I, 1973, 223.

Guntrip, Harry. Psychoanalytic Theory, Therapy, and the Self. New York: Basic Books, 1971.

Haeberle, Erwin. The Sex Atlas. New York: Seabury Press, 1978.

Hallingby, Leigh. "Human Sexuality in the Social Work Education Curriculum at the University of Pennsylvania." Unpublished Master's thesis, School of Social Work, University of Pennsylvania, 1972.

Hamilton, Gordon. Theory and Practice of Social Casework. New York: University Press, 1959.

Harlow, Harry. Learning to Love. New York: Aronson, 1974.

Hartman, William E. and Fifthian, Marilyn A. Treatment of Sexual Dysfunction. Long Beach: Center for Marital and Sexual Studies, 1972.

Haselkorn, Florence. Casebook in Family Planning. New York: Council on Social Work Education, 1971.

Higginbotham, H. and Farkas, G. "Basic and Applied Research in Human Sexuality," Handbook of Behavior Therapy. Joel Fischer and Harvey Gochros, eds., New York: Pergamon Press, 1979.

Hollowitz, Emanuel and Shore, David. "Teaching Human Sexuality," Health and Social Work. III, November, 1978, 133.

Jackson, Josephine A. "Clinical Social Work: Definition, Values, Knowledge, and Practice," Unpublished Doctoral thesis, Institute for Clinical Social Work, Sacramento, 1979.

Johnson, Gene. "A Study of Sex Education in the Schools of Social Work," Unpublished professional project, School of Social Work, University of Washington, 1972.

Kaplan, Helen S. "Editorial," Journal of Sex and Marital Therapy, II, 1976, 84.

_____. The New Sex Therapy. New York: Brunner/Mazel, 1974.

_____. "Sex Therapy: An Overview," Sexuality and Psychoanalysis. Edward Adelson, ed. New York: Brunner/Mazel, 1975.

Kaplan, Louise J. Oneness and Separateness: From Infant to Individual. New York: Simon and Schuster, 1978.

Kardner, Sheldon H., Fuller, M., Mensch, N. "A Survey of Physicians' Attitudes and Practices Regarding Erotic and Nonerotic Contact with Patients." American Journal of Psychiatry, CXXX, 1973, 1077-1081.

Katchadourian, Herant, and Lunde, Donald. Fundamentals of Human Sexuality. 2nd ed. New York: Holt, Rinehart and Winston, 1975.

Kegel, Arnold. "Sexual Functions of the Pubococcygeus Muscle," Western Journal of Surgery. LX, 1952, 521-524.

Kinsey, Alfred D. et al. Sexual Behavior in the Human Male. New York: W. B. Saunders Co., 1948.

Kunkel, Dale. "The Future of Sex: Implications of Social Work Education." Doctoral dissertation, Tulane University, 1978.

_____. ed. Sexual Issues in Social Work. University of Hawaii, Honolulu, 1979.

Leif, Harold. "Introduction to Sexuality," The Sexual Experience, Benjamin Saddock and Harold Kaplan, eds. Baltimore: Williams and Wilkins, 1976, 1.

Len, Michael and Fischer, Joel. "Clinicians' Attitudes Toward and Use of Four Body Contact or Sexual Techniques with Clients." The Journal of Sex Research. XIV, 1978, 40-49.

LoPiccolo J. and LoPiccolo L. eds. Handbook of Sex Therapy. New York: Plenum Press, 1978.

Mahler, Margaret. et al. The Psychological Birth of the Infant. New York: Basic Books, 1975.

Masters, William H. "Repairing the Conjugal Bed." Time. May 25, 1970, 40.

Masters, William H. and Johnson, Virginia E. Human Sexual Inadequacy. Boston: Little, Brown and Company, 1970.

_____. Human Sexual Response. Boston: Little, Brown and Company, 1966.

_____. "An Interdisciplinary Approach to Sexuality." Personnel and Guidance Journal. 54, 1976, 368.

_____. "Principles of the New Sex Therapy." American Journal of Psychiatry. CXXXIII, 1976, 552.

Mazer, Cliff. "The Development of Social Work Education in Human Sexuality: A Historical Review." Unpublished paper presented November, 1978.

Money, John. "The Development of Sexology as a Discipline." Journal of Sex Research. XII, 1976, 85.

_____. "Paraphilias." Handbook of Sexology. John Money and Herman Musaph. eds. New York: Elsevier, 1978.

Money, John and Musaph, Herman, eds. Handbook of Sexology. New York: Elsevier, 1978.

Musaph, Herman. "Skin, Touch and Sex." Handbook of Sexology. New York: Elsevier, 1978.

National Registry, 1978. American Association of Sex Educators, Counselors and Therapists: Washington, D. C.

Pinkus, Helen. et al. "Education for the Practice of Clinical Social Work at the Master's Level: A Position Paper." Clinical Social Work Journal, V, 1977, 259.

Rosen, A. et al. "Pretreatment Expectancies and Interview Content." Human Sexuality and Social Work. New York: Association Press, 1972.

Rubenstein, E., Green, R. and Brecher, E. eds. New Directions in Sex Research. New York: Plenum Press, 1975.

Sadock, Benjamin J., Kaplan, Harold L., Freedman, Alfred M. eds. The Sexual Experience. Baltimore: Williams and Wilkins Company, 1976.

Sadock, Virginia A. "Marital Therapy." Sexual Experience. Benjamin Sadock et al. eds. Baltimore: Williams and Wilkins Company, 1976.

Schultz, LeRoy. "Ethical Issues in Treating Sexual Dysfunctions." Social Work. XX, 1975, 128.

_____. Personal communication. April, 1980.

_____. "A Survey of Social Workers' Attitudes and Use of Body and Sex Psychotherapies." Clinical Social Work Journal, III, 1975, No. 2, 90-99.

Semans, J. "Premature Ejaculation." Southern Medical Journal. XLIX, 1956, 353-357.

Sex Information, Education Council of the United States, "SIECUS Convenes Task Force on Sexuality and Social Work." SIECUS Report. I, 1973.

Sharpe, L., Kuriansky, J. and O'Connor, J. "A Preliminary Classificiation of Human Functional Sexual Disorders." Journal of Sex and Marital Therapy. II, 1976, 106.

Snyder, Arthur J. "Medical Reaction to Sex Research." Chicago Daily News carried in the San Francisco Chronicle. April 23, 1966.

Sollod, Robert N. "Behavioral Psychodynamic Dimensions of the New Sex Therapy." Journal of Sex and Marital Therapy. I, 1975, 339.

Stephens, Gwen. "A Theory of Sexuality." American Journal of Nursing. January, 1978, 74.

Tanner, Libby A. "Teaching a Course in Human Sexuality in a Graduate School of Social Work: Strategy and Content." The Family Coordinator. July, 1974.

Thoman, Evelyn and Gaulin-Kremer, Elise. "Correlates of Human Parental Behavior: A Review." Handbook of Sexology. J. Money and H. Musaph, eds. New York: Elsevier, 1978.

"Using Touch in the Therapeutic Relationship." Sexuality Today. III, April, 1980, 1.

Valentich, Mary and Gripton, James. "Teaching Human Sexuality to Social Work Students." The Family Coordinator. July, 1975.

Wachtel, Paul. Psychoanalysis and Behavior Therapy. New York: Basic Books, 1977.

Woody, R. H. Psychobehavioral Counseling and Therapy. New York: Appleton-Century-Crofts, 1971.

World Health Organization. The Teaching of Human Sexuality in Schools for Health Professionals. Public Health Paper #57, D.R. Mace, R.H.O. Bannerman, and J. Burton, eds.

APPENDIX A

STATUTES AND CODES

ASSEMBLY BILL NO. 4178

CHAPTER 1433[1]

An act to add Section 25 to the Business and Professions Code, relating to licensing requirements.

(Approved by Governor September 30, 1976. Filed with Secretary of State September 30, 1976.)

LEGISLATIVE COUNSEL'S DIGEST

AB 4178, Vasconcellos. Human sexuality; licensing requirements.

Existing law does not require any licensee of the Business and Professions Code to complete a course in human sexuality.

This bill would require any person seeking or renewing a license, registration, or first renewal of such license as a licensed clinical social worker and any person seeking a license as a marriage, family and child counselor or psychologist to show evidence of completed training in human sexuality, as defined, as a condition of licensure or registration. This bill would also provide that such training shall be creditable toward continuing education requirements as deemed appropriate by the regulatory agency. The bill would require the administrative agency regulating a particular business or profession to determine the content and length of such training.

The bill would require any licensing board or agency proposing to establish a training program in human sexuality to consult with other such boards or agencies which have established or propose to establish such training programs to insure compatibility.

This bill would provide that the act is to be operative January 1, 1978, except that those provisions requiring the agency to determine the length and content of training, to evaluate training, and to report to the Legislature, would become operative on the effective date of the act.

The people of the State of California do enact as follows:

SECTION 1. Section 25 is added to the Business and Professions Code, to read:

25. Any person applying for a license, registration, or the first renewal of such license, after the effective date of this section, as a licensed marriage, family and child counselor, a licensed clinical social worker or as

a licensed psychologist shall, in addition to any other requirements, show by evidence satisfactory to the agency regulating such business or profession, that he or she has completed training in human sexuality as a condition of licensure. Such training shall be creditable toward continuing education requirements as deemed appropriate by the agency regulating such business or profession, and such course shall not exceed more than 50 contact hours.

The Psychology Examining Committee shall exempt any persons whose field of practice is such that they are not likely to have use for this training.

"Human sexuality" as used in this section means the study of a human being as a sexual being and how he or she functions with respect thereto.

The content and length of such training shall be determined by the administrative agency regulating such business or profession and such agency shall proceed immediately upon the effective date of this section to determine what training, and the quality of staff to provide such training, is available and shall report its determination to the Legislature on or before July 1, 1977.

In the event that any licensing board or agency proposes to establish a training program in human sexuality, such board or agency shall first consult with other licensing boards or agencies which have established or propose to establish a training program in human sexuality to insure that such programs are compatible in scope and content.

SEC.2. This act shall become operative January 1, 1978.[2]

Title 16, Chapter 18, Section 1878, of the California Administrative Code, reads as follows:

1878. HUMAN SEXUALITY TRAINING. All persons applying for a license as a Licensed Clinical Social Worker on or after January 1, 1980, shall, in addition to all other requirements for licensure, have completed coursework or training in human sexuality which meets the requirements of this section. Such training shall:

(a) Be completed after January 1, 1970.

(b) Be obtained

(1) In an accredited educational institution, including extension courses offered by such institutions, or

(2) In an educational institution approved by the Department of Education pursuant to Section 94310(b) of the Education Code, including extension courses offered by such institutions, or

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[1] Chapter 1433 of Statutes of 1976 (AB4178).

[2] Chapter 92 of Statutes of 1978 (AB 1578) changed the date to January 1, 1980.

(3) From a continuing education provider approved by a professional association, or

(4) In a course sponsored or offered by a professional association, or

(5) In a course sponsored, offered, or approved by a state, county or local Department of Health Services or Department of Mental Health.

(c) Have a minimum length of ten (10) actual hours.

(d) Include the study of physiological-psychological and social-cultural variables associated with sexual identity, sexual behavior or sexual disorders.

All applicants shall provide the Board with documentation of completion of the required human sexuality training.

It is the intent of the Board that all persons licensed to practice Clinical Social Work have a minimal training in human sexuality. It is not intended that by complying with the requirements of this section only, a practitioner is fully trained in the subject of sex therapy.

1878.2. RENEWAL DEPENDENT UPON TRAINING DOCUMENTATION. Any licensed Clinical Social Worker who has not submitted documentation meeting the human sexuality training requirements shall not have the license renewed until such documentation or if incomplete documentation is submitted, then the Board must return the renewal fee. The renewal fee, at the time of the submitting of satisfactory documentation, must include any applicable delinquent fees.

1878.1. HUMAN SEXUALITY TRAINING REQUIRED FOR LICENSEES. All licensed Clinical Social Workers shall provide the Board with documentation of completion of human sexuality training required in Section 1878 at the time of the first renewal of his or her license after January 1, 1980.

APPENDIX B

SURVEY INSTRUMENT

Dear Colleagues,

Here are three cases. Please read the summary of each and respond to the statements accompanying the vignette. Please rate each statement as indicated. These statements are not intended to be mutually exclusive.

Thank you for your cooperation.

Beverlee H. Filloy, M.S.W.
Institute For Clinical
Social Work

March 9, 1979

Referral source: Personal physician.

Presenting telephone complaint: "Trouble" adjusting to single life.

Presenting complaint in session: Impotence.

Howard, a robust 54 year old man, in the first session tells you he is experiencing some depression, anxiety and loneliness after the termination, six months ago, of his 34 years of marriage. He is surprised at his reaction since it was an unhappy marriage for many years after the kids left and he was "glad" she got the divorce. Howard, a stable blue collar worker, was a faithful husband throughout all those years, but she constantly accused him of being a pushover for other women; he used to wish he were free. Now that he is, he frequents bars, women seem to seek him, but he can't get "with it".

In fact, the few times he has tried to be intimate sexually with women, he could not, for the first time in his life, get an erection. He is feeling very discouraged about a lonely future and embarrassed to try to make new sexual relationships. Although he has recently been seeing more of one women he likes, he is threatened about the possible sexual failure and thinks he will change bars to avoid her and facing the issue. He has seen his physician and is in excellent health, "So the doctor said I should talk to you". Then, bluntly at the end of the session, "Do you think you can help me be a man again or am I too old?"

Do you agree or disagree with the following views?

Circle A or D below please.

1.	Howard, as a means of improving his sexual functioning, needs to examine, in depth, his passivity with women.	A	D
2.	Howard is experiencing sexual difficulties as a symptom of depression.	A	D
3.	Howard's erectile problems cannot be helped until he resolves other issues.	A	D
4.	Howard requires immediate help with his erectile problems before other issues should be addressed.	A	D
5.	Howard is experiencing depression as a result of his sexual dysfunction and lowered self-esteem.	A	D
6.	Given Howard's age and life style, prognosis for his regaining sexual functioning is poor.	A	D

CASE I (con't)

Please check the appropriate response below for each item as: Likely (L), Undecided (U/D) or Unlikely (U/L)

How likely are you to recommend or use a plan to:	L	U/D	U/L
1. Work with Howard on a short term basis, helping him aquire new social skills (assertion training, leisure time pursuits, communication)?	___	___	___
2. Explore Howard's developmental history in depth to clarify where the pathology lies?	___	___	___
3. Refer Howard to his physician for medication in addition to psychotherapy?	___	___	___
4. Provide Howard with sexual education and counseling (e.g., information regarding alcohol's effects, performance anxiety, etc.)?	___	___	___
5. Help Howard accept his need for long term therapy to work through his psychological conflicts?	___	___	___
6. Offer Howard an individual program in directed sex therapy with assignments (e.g., self-stimulation, reading, etc)?	___	___	___
7. Consider with Howard seeking a female partner for directed sex therapy?	___	___	___
8. Consider with Howard your providing a female surrogate?	___	___	___
9. Involving Howard and his partner in sex therapy with a male-female co-therapy team?	___	___	___
10. Refer Howard to a sex therapist?	___	___	___
11. Help Howard accept the inevitable sexual changes of aging and work through his feelings of loss?	___	___	___

_____

Any other plan you would likely recommend?

Referral source: Local mental health agency.

Presenting request by telephone: "Personal and marital problems".

Presenting complaint: Depression and anxiety re sexual apathy.

Lena, a 22 year old woman, in the first session, at times weeps, because her marriage is failing and she blames herself. She and her husband, Kent, have a good relationship after four years of marriage, he just got a better job, they have purchased their first home and will have more space for themselves and the two children, ages one and three. Everything "should" be beautiful, but she is depressed, fatigued, tearful daily, feels "rotten" (guilty) constantly about her sexual apathy and the disappointment she senses in her husband. He is quiet, doesn't complain, but she knows every night when he looks at her "that way" that he is thinking about how things used to be between them sexually, (before and after their marriage) up until about two years ago.

Even now, in those rare instances when she can accomodate his wishes, she achieves orgasm readily, but sex seems like a chore, a duty. She is afraid he will leave her, although he probably won't divorce her because they are both strict Catholics. In fact, sometimes she thinks she should have been a nun since she feels as she does about sex. It's funny, but she was just really beginning to relax and enjoy sex after their marriage and the first baby, when her attitude began to change. Now she can hardly bear for Kent to hug her; they're both miserable and it's her fault.

Kent wants to help her but she doesn't know what to ask him to do. She has talked with no one since she is shy and doesn't have any friends since she left her job. Lena couldn't talk to her mother because of her mother's "negative attitude" toward men and sex because of the troubles with Lena's father.

She is home alone with the children and the problem is on her mind; maybe she should get a job and try to forget it. If she is going to need a lot of professional help, money will be a big problem anyway.

Do you agree or disagree with the following views?

Circle A or D below please.

1.	Lena's sexual apathy is a result of her depression and isolation.	A	D
2.	Lena's sexual symptoms are an expression of interpersonal strains between herself and Kent.	A	D
3.	Lena is reacting to cultural-religious training and a conflict re sexual pleasure.	A	D
4.	Lena's symptoms are a reflection of her developmental experiences with clues of her parent's dissatisfactions.	A	D
5.	Lena's sexual concern requires immediate help before other issues should be addressed.	A	D
6.	Lena's depression and guilt are a result of lowered self-esteem.	A	D
7.	Given Lena's age, relationships and background, the prognosis is good.	A	D

CASE II (con't)

Please check the appropriate response below for each item as: Likely (L), Undecided (U/D), or Unlikely (U/L).

How likely are you to recommend or use a plan to:	L	U/D	U/L
1. Work with Lena on a long term basis toward alleviating depression, exploring intrapsychic issues?	___	___	___
2. Work with Lena on a short term basis toward improving her immediate situation to decrease her isolation, increase the communication with Kent?	___	___	___
3. See Lena and Kent, as a couple, exploring their interpersonal relationship in general?	___	___	___
4. See Lena and Kent, as a couple, exploring with a co-therapist of the opposite sex, their interpersonal relationship in general?	___	___	___
5. Proceed with the couple in time-limited, directed sex therapy including pleasuring assignments, sexual materials etc.?	___	___	___
6. Proceed with the couple in time-limited, directed sex therapy including pleasuring assignments, sexual materials etc. working with a co-therapist of the opposite sex?	___	___	___
7. Offer Lena an individual program of directed sex therapy assignments (self-pleasuring, reading, fantasy etc.)?	___	___	___
8. Refer Lena elswhere for sex therapy?	___	___	___
9. Refer Lena and Kent elsewhere for sex therapy?	___	___	___

_____

Any other plan you would likely recommend?

Referral source: Attorney-friend (former client).

Presenting telephone complaint: Marital crisis and personal distress.

Presenting complaint in session: Acute anxiety, irritability, emotionally labile in connection with possible loss of marriage.

Stan, age 38, is frantic and self-condemming over the threat of separation by his 25 year old wife, Julie, a part-time psychology student. She has revealed a two year affair with a prominent physician; both are considering divorcing in order to marry. Julie will remain "awhile" for the sake of the children, ages three and five, if Stan can "become responsive to her emotional needs."

Stan gives a history highlighted by the onset of a chronic disease in his late adolescence and the "loss" of a decade as he was partly incapacitated, withdrawn and depressed. Ultimately, the disease has been controlled through medication and while there is a minor disability and some pain, he functions well in his work as an accountant; building up his business, pushing himself for Julie and the boys.

Over the past 10-15 years he has occasionally considered the idea of psychotherapy, but it seemed a luxury; now he wants very much to understand himself better, his lack of friends, compulsion for work, and how to be a better husband and father. Before Julie confronted him, he thought everything was fine; he knew she had been talking with a counselor but assumed it was a part of her studies. Now he knows how wrong he was, he wonders why he had been so blind; he sobs briefly. He is having trouble with mood swings and lack of concentration. Julie reports her female counselor advises against marital work and for now she declines permission for contact with the counselor. Stan wants to work with you regardless.

As your work proceeds Stan regains control at the office, begins to recognize his anger at Julie's secret affair and makes some association to events in a period of his illness. You feel the work is progressing well.

In the ninth session, Stan reports a recent argument (until now the couple has rarely disagreed openly) in which he demanded Julie stop seeing her lover. Julie retorted that Stan had "never satisfied" her sexually, he's never "lasted long enough" or been interested "frequently enough" and her counselor said he ought to see a sex therapist. He is hurt, surprised and very threatened by this, since he had believed their sexual adjustment was one of the positives throughout the marriage. He is, however, willing to try to please Julie. He asks your recommendation about sex therapy since he's long had worries about his "vigor".

Do you agree or disagree with the following views?

Circle A or D below please.

1. Stan's sexual difficulties are due to a recurrence of depression and anxiety associated with major loss. A D

2. Stan needs immediate help with his sexual complaints before continuing with other therapy. A D

3. Stan's sexual concerns are more a reflection of Julie's anger than his dysfunction. A D

4. Stan's sexual difficulties are likely attributable to his physical disease and/or medication. A D

5. The sexual problems cannot be helped in all probability until Stan and Julie resolve other marital strains. A D

6. The sexual problems cannot be helped in all probability until Stan resolves other intrapsychic conflicts. A D

7. Given Stan's health and circumstances, prognosis for improved sexual functioning is poor. A D

8. The sexual concerns cannot be dealt with in the absence of Julie's participation in the sex therapy. A D

9. There is a question of about the nature of Stan's disorder. A D

CASE III (con't)

Please check the appropriate response below for each item as: Likely (L), Undecided (U/D), or Unlikely (U/L).

How likely are you to recommend or use a plan to:	L	U/D	U/L
1. Continue working as you have been with Stan, through insight and awareness, postponing any sex therapy?	___	___	___
2. Continue working as you have been with Stan and refer him elswhere for sex therapy concomitantly?	___	___	___
3. Set aside your on-going work and focus on sex counseling education; teach Stan techniques for prolonging intercourse and provide information on female sexuality?	___	___	___
4. Advise against sex therapy for Stan because of the lack of cooperation by Julie; strains between them will interfere with such treatment?	___	___	___
5. Clarify with Stan his historical and present sexual experiences to determine what dysfunction exists?	___	___	___
6. Urge Stan to gain Julie's cooperation in marital therapy?	___	___	___
7. Urge Stan to gain Julie's cooperation in sexual therapy?	___	___	___
8. Attempt to work out a plan for Julie and Stan in co-therapy (involving Julie's counselor or other professional) toward resolving their marital issues?	___	___	___
9. Interrupt your current work with Stan and offer a directed program in sex therapy for him individually?	___	___	___
10. Suggest the use of a surrogate partner for Stan in sex therapy if Julie is unwilling?	___	___	___

_____

Any other plan you would likely recommend?

Please read the following statements and indicate the extent to which you agree or disagree with each of them by checking the appropriate category.

	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
1. Sexual dysfunctions, where not organically based, are symptoms of underlying psychopathology.	___	___	___	___	___
2. I see the current interest in sex therapy as part of a passing professional "fad".	___	___	___	___	___
3. Those practicing sex therapy in California must, by State law, be licensed and have specialized training.	___	___	___	___	___
4. I would not include sex therapy in my practice because of its emphasis on behavior modification techniques and directing clients.	___	___	___	___	___
5. I believe the most effective psychotherapy is one-to-one: i.e., one client, one therapist.	___	___	___	___	___
6. Sensate focus refers to stimulating and being stimulated to orgasm.	___	___	___	___	___
7. A non-erotic therapist-client physical contact, if acceptable to the client, can be beneficial to the therapy.	___	___	___	___	___
8. "Contracting" for a time-limited therapeutic sequence (i.e., certain number of sessions etc.) may be the treatment of choice.	___	___	___	___	___
9. The goal of sex therapy is to teach people how to function sexually.	___	___	___	___	___
10. Sex therapy has little relevance to traditional Freudian and neo-Freudian theory.	___	___	___	___	___
11. If a couple is openly hostile to each other, they are poor candidates for sex therapy.	___	___	___	___	___
12. Use of sex surrogates is specifically unlawful in California.	___	___	___	___	___

	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
13. When interpersonal, i.e., relationship, issues play a major role in sexual problems, treatment of choice requires seeing the couple as opposed to an individual alone.	___	___	___	___	___
14. I am more comfortable with homosexual clients of my own sex, than the opposite sex.	___	___	___	___	___
15. Under some circumstances, I would teach masturbation techniques to a client.	___	___	___	___	___
16. Sex therapy with a heterosexual couple ideally utilizes a male-female therapy team.	___	___	___	___	___
17. Brief therapeutic interventions can have long-term benefits.	___	___	___	___	___
18. I am more comfortable discussing sexual material with a client of my own sex than the opposite sex.	___	___	___	___	___
19. I am more comfortable discussing sexual material with a heterosexual client than with a homosexual client.	___	___	___	___	___
20. The goal of sex therapy is to remove obstacles to sexual functioning.	___	___	___	___	___
21. Treatment of sexual dysfunction may be the recommended course even when there is overt evidence of psychopathology.	___	___	___	___	___
22. It is my practice to inquire early in my work with clients about their sexual functioning.	___	___	___	___	___
23. I am more comfortable discussing sexual material with couples than with individual clients.	___	___	___	___	___
24. To be effective, sex therapy need not attend to the client's past history since the focus is current performance.	___	___	___	___	___

	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
25. I am more comfortable discussing sexual material with a client much younger than I am than with one much older.	___	___	___	___	___
26. I am skeptical of any therapeutic approach such as sex therapy which focuses on symptom relief.	___	___	___	___	___
27. Seeing the couple (conjoint) therapy is contraindicated because it contaminates the transference.	___	___	___	___	___
28. I am more comfortable discussing sexual material with a client of my own racial background than of another race.	___	___	___	___	___
29. The current interest in sex therapy indicates that such techniques are becoming a standard part of clinical social work.	___	___	___	___	___
30. I am more comfortable discussing sexual material with married clients than with unmarried clients.	___	___	___	___	___
31. An erotic therapist-client physical contact (including intercourse), if acceptable to the client, can be beneficial to the therapy.	___	___	___	___	___
32. Working with a co-therapist is a handicap to therapy since it "dilutes" the transference.	___	___	___	___	___

This is the final section for you to complete: a few facts about yourself. Please answer every question.

Thank you.

AGE _____ SEX _____ M.S.W. (DATE) _____

1. Did your undergraduate or graduate education include a specific course in human sexuality?

   YES ___ NO ___ (If "No" skip to #2)

   IF YES: a) Was it elective? ___ or required? ___ (check one)

   b) How many hours/credits? ___

   c) Has it been helpful in yourwork? YES ___ NO ___

   Comment: _____

   _____

2. Have you taken any courses or workshops in general human sexuality as opposed to sex therapy, since graduate school?

   YES ___ NO ___ (If "No" skip to #3)

   IF YES: a) Under whose auspices? _____

   b) About what year? _____

   c) How long in hours? 1-14 ___ 15-30 ___ over 30 ___

   d) Has it been helpful in your work? YES ___ NO ___

   Comment: _____

   _____

3. Have you had any training specifically in sex therapy?

   YES ___ NO ___ (If "No" skip to #4)

   IF YES: a) Under whose supervision? _____

   b) About what year? _____

   c) Length of training in hours: 1-14 ___ 15-30 ___ 30-70 ___

   over 70 ___

   d) Has it been helpful inyour work? YES ___ NO___

   Comment: _____

   _____

4. Have you met the recent Board of Behavioral Science Examiners sex education requirements for relicensure by 1980 as you understand these? YES ___ NO ___ UNCERTAIN ___

   IF YES: a) What year? _____

   b) Under whose auspices? _____

5. What, if any specific readings in the sexual field have you found helpful in your work? Please list briefly.

6. Do you include sex education or counseling as a part of your practice?

   YES ___ NO ___

   IF YES, because _____

   _____

   _____

   When did you begin? _____

   IF NO, because _____

   _____

   _____

7. Do you include sex therapy as a part of your practice?

   YES ___ NO ___

   IF YES, because _____

   _____

   _____

   IF NO, because _____

   _____

   _____

8. Which of the following specialized materials expressly dealing with sexual concerns do you use with clients? (Check all that apply.)

Diagrams ___

Charts ___

Books ___

Films ___

Slides ___

Other ___ (please identify) _____

_____

None ___

Thank you for your participation. I would appreciate your looking back to be certain every statement or question has been answered.