# Reflections on Teaching Sexual Health in Social Work

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**Abstract**: This article presents the personal narrative of the author, who discusses the professional and academic experiences that led to her becoming a sex therapist and teaching a sexual health course in a Master of Social Work program. It discusses how the course came into existence and why it is needed in the profession, and it provides a reflection on the course delivery over the past ten years. In addition, the personal narrative and academic experiences of the author, an assignment that challenges students' values regarding sexual health, and a framework for asking clients about their sexual health that can be adapted to almost any behavioral and mental health setting are provided.

***Keywords***: sexual health, mental health, teaching, sexuality

"Talk is the key to the search for understanding sexual thoughts, sexual feelings, and sexual actions—ultimately it is the key to helping patients."
~William L. Maurice, 1999, *Sexual Medicine in Primary Care*

I always knew I wanted to be a social worker in the mental health field. Talking with others about who we are as individuals and collectively, gaining insights into why we behave the way we do, and understanding how this impacts our relationships appealed to me from a young age. While my parents encouraged counseling and open discussions about mental health, one topic that was not open for discussion was sex. It was made clear at an early age that sex was an act between a man and woman who were married, and it was only during that phase of one's life that it could be discussed. I received minimal sexual education in primary and secondary school. Growing up in a conservative, Irish, Catholic family and attending Catholic schools did not encourage an open dialogue about sexual desires, needs, or functioning, particularly for women. And the idea that sex is for pleasure, not just reproduction, was novel at best. It was not until I went to college that I realized not everyone was raised the same way and that talking about sex was not shameful or was not to be avoided. This realization came both from formal education in human development and family studies, and then informally from my diverse group of friends.

There were two distinct experiences in my undergraduate career that led me toward the path of studying sexual health and being a sex therapist. During my sophomore year, I had the opportunity to take an introductory human sexuality course. I sat in a lecture-based class with over 400 other students, and each week I learned about the many facets of human sexuality; the importance of sexual development, sexual functioning and dysfunction; the complexities of sexual matters in relationships; and the influence of media, culture, and history on sexual practices and beliefs. In addition to the lectures, each person was assigned to meet once a week with a discussion group led by teaching assistants (TAs) to explore our beliefs, values, and opinions about human sexuality. The first few group sessions were tense, and it became obvious that many of us—myself included—had difficulty talking about sexual matters without embarrassment, shame, or other emotions. By the end of the course, my understanding of human sexuality had increased, but more importantly, my comfort level in discussing it had increased. I was fascinated with the many complexities of human sexuality and wanted to know more.

My interest in the topic did not go unnoticed, and the next semester I was asked to be a teaching assistant to lead discussions like the ones in which I had participated. In addition to preparing course lessons, the professor provided the TAs with advanced education in sexual health across the lifespan. This additional education and knowledge, as well as the opportunities to lead discussions, fueled my interest and curiosity as to why sex, such an important aspect of life, was so taboo. From then on, I found myself reading books in my spare time on various sexual health-related topics, working in the world of sexual health and HIV education, and volunteering at various health organizations doing peer counseling and sexual health education.

The second distinct experience I had was on a much more personal level. During my junior and senior years, I lived in a cooperative on campus with approximately 25 other students. It was much like living in a dorm in that we had our own rooms (or maybe shared with one roommate), shared common areas and bathrooms, and had our own meal plan in which we took turns cooking meals for one another. Our house was known on campus for being LGB (lesbian, gay, bisexual) friendly, which in the 1990s was not always the case. Most of the residents also became friends. At one point during my time there, one of my friends was diagnosed as HIV positive. This news was heartbreaking and there was a lot of discussion about the illness, treatments, and whether or not certain people could be told for fear of their reactions. Back then, HIV was highly stigmatized and safety was a real concern. That experience personalized sexual health in a way like never before. It made me challenge my own beliefs about sexually transmissible infections, the impact of receiving a diagnosis, sexual health safety, and the many complexities of living with HIV. For several months following the diagnosis, I struggled with knowing exactly what to say to be supportive to my friend. It was then that I turned to counseling for support and found that the counselor with whom I was working did not feel comfortable with the topic and often changed the subject. The counselor's reaction mirrored the stigma and ignorance that were associated with HIV at that time, and it made me realize that just because someone was trained as a helping professional did not mean they were comfortable talking about sexual health. These experiences along with two years of HIV education and case management solidified my desire to study sexual health more formally.

In my graduate course work, I trained and worked in a sex therapy clinic at a university hospital, and upon graduation completed a year-long fellowship in sex therapy. In order to gain additional experiences in mental health treatment, I went on to work in two mental health agencies providing general counseling. In addition, I became an adjunct professor for several undergraduate courses in social work practice. During these experiences, a similar theme arose that I could not ignore. From the students I taught in the undergraduate courses who wrote about their discomfort in discussing sexual topics in their class when given an assignment about the importance of human sexuality in professional practice, to fellow graduate students who sat in classes with me who turned to me to answer questions about sexual health because they knew it was my passion instead of having to challenge their own comfort level, to the practitioners I worked with in several mental health-related agencies that simply referred cases having to do with sexual health concerns, the majority were not comfortable discussing sexuality and sexual health. I remember distinctly being told by a colleague that in her five years at the agency in which we worked, her supervisor not once asked about the sexual health concerns of clients. When my colleague finally had enough courage to bring it up to her supervisor, her questions

were quickly dismissed and she was told to focus on "more important" treatment issues. This baffled me. During my experience of being at that particular agency only six months, at least half of the clients I worked with wanted more information or had a concern about their sexual health. And within a year of working there, 95% of my caseload had a sexual concern as one of the main counseling topics.

Within a few months of employment at both of the mental health agencies in which I worked, it became quickly known that I had training in and passion for working with topics of sexual health. I did several trainings for other practitioners and supervisors on how to bring up sexual topics with clients and supervisees. In these trainings, I began asking about training in human sexuality from a knowledge perspective and from the perspective of how practitioners addressed such topics and their comfort levels with doing so. Often when I asked these questions, I received a less-than-favorable response. A few people would mention a course or two they had taken on human sexuality at some point in their college career; very few reported any additional training specific to sexual health treatment, and most suddenly found doodling in their notebook much more interesting than commenting on their training in sexual health. While this was not surprising, it was disheartening. Sexual health is woven into the tapestry of each of our lives. Not learning about it perpetuates the forbidden nature of sex and ultimately damages relationships, self-esteem, and can lead to other health and mental health concerns (Russell, 2012). It was this realization that caused me to go on to pursue my doctorate, during which time I surveyed mental health practitioners working with children and adolescents in a community mental health setting about their knowledge, attitudes, and clinical behaviors regarding sexual health. In my study, I used the World Health Organization's (2015) definition that states:

> Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. (p. 5)

I provided participants with surveys regarding their knowledge, values, clinical behaviors, and training in sexual health. The findings of my study did not surprise me. The majority of clinicians did not have formal training in sexual health and were not comfortable nor believed themselves to be competent in discussing sex with clients. My results did indicate that it was not the amount of knowledge that correlated with whether or not a clinician discussed sex, but rather their attitude and openness. I realized that while a course in human sexuality is helpful, it really is not the knowledge that helps the clinician; rather, it is knowing their own values, beliefs, and being open to different perspectives. This was just as, if not more, important than knowledge alone. Thus, practitioners must not only be knowledgeable about sexual health, but also have a proactive, positive, and respectful approach to addressing sexuality. To be able to better understand their clients' points of view, clinicians must assess their own belief systems and values. Because each person's sexual health is unique, clinicians must be open to asking highly sensitive questions and willing to work with clients who have different beliefs and practices from their own. Sexual health treatment is a complex field of practice that takes time and clinical

skill to develop. In order to do this, students in graduate programs must receive training on sexual topics, as well as how to address them in practice in an ethical and unbiased manner. Knowing that fewer than 15% of clinicians actually addressed sexual health with clients (Russell, 2012) led me to create a graduate Master of Social Work course entitled, Sexual Health in Professional Practice.

I first taught this class in a traditional face-to-face format, in which students engaged in several role plays, video tapings, and analyses of their clinical skills in addition to readings and assignments. As I was teaching the course for the first time, I became aware that I had made an error. I assumed that all the students had prior education in human sexuality and were ready to advance their skills in clinical settings, even though I knew this anecdotally. Three-fourths of the class had no previous training in sexuality. I quickly had to regroup and teach the basics of human sexuality. At the end of the course, 84% of students stated they felt more comfortable with discussing sexual health than before taking the course. I was pleased with this percentage, but I also believed it could be higher. In addition, 75% of students commented on their evaluations that this was the first time anyone had discussed sexual health as a regular part of all stages of the life course, and not only did they increase their knowledge, but their attitudes toward addressing sexual health in a multitude of professional settings were also challenged. Based on student feedback, both in writing via evaluations and in classroom discussions, I changed the course format to include a hybrid component.

In the online hybrid component, students were able to complete modules to increase their knowledge of the basics of sexuality and sexual health and view videos of clinicians performing sexual health interviews that potentially led to the development of more clinical skills. By having students participate in these online activities, it allowed students more time to process the material at their own pace. The online component complemented the face-to-face format well. Of the students who participated in the hybrid format, 89% stated they felt more comfortable in addressing sexual health with clients. To be honest, I was originally resistant to moving this course to a hybrid format. So often sexual health is not discussed openly and I worried that by moving the course online, it would perpetuate this; luckily, the opposite was true. Students liked the hybrid piece and reported that it allowed them “time to think and process” the many different sexual health topics presented in the course. By learning the basics of human sexuality outside of class, it opened the remaining face-to-face classes to explore their own beliefs and values of sexual health and how to increase their comfort levels. I did this by providing specific engagement activities and a framework to increase their comfort level—as well as their confidence over time—with discussing sexual health. Two activities in the class which have had consistently positive responses from students over the ten years of teaching this course are provided in more detail below. The first is the library activity and the second is the application of the Permission, Limited Information, Specific Suggestion, Intensive Therapy (PLISSIT) model (Annon, 1976).

In the second week of class, students are asked to take a trip to their local library and ask the librarian to help them find a book on a sexual health topic of their choice. Common choices for many students include books on how to explain reproduction to children; adolescent sexuality; infertility; and sexual dysfunction. Students are not allowed to buy books online, and they must

have the librarian with whom they work sign off on helping them find a book. In today's day and age, many people are curious about sexual health and are comfortable buying books or other educational materials at home. Asking for help to find such material brings up a lot of mixed reactions for students. Some report that they had no problem asking the librarian for help. Others admit they asked for a book on a less risqué topic or on a socially acceptable topic, such as explaining sexual reproduction to children or health-related books so they wouldn't feel judged or embarrassed. I have had students who have refused to complete the assignment, though this is much less rare. Part of the assignment is that they are not to disclose they are there on an assignment for a graduate class until after they have their chosen book in hand. They bring their books to class and they each provide a reference for other students. The purpose of the activity is two-fold: first, to find a book on a sexual health topic, and second, to discuss their reactions to having to ask for help in finding the book. So often, we as practitioners take for granted how difficult it can be to ask for help and to discuss sexual topics with other people. This activity allows students to challenge their own comfort level as well as become more empathetic to clients. Students report that this is one of their favorite activities of the course because it is experiential and they become aware of their feelings and reactions about going into the public realm searching for sexual health information. They place themselves in "the shoes" of their potential clients and must address their own biases and emotional reactions to others' possible perceptions of what it means to obtain information about sexual health.

In teaching students how to address sexual health in clinical practice, I have found it helpful to provide them with a framework for intervention that helps them address sexual health. The model I use stems from the medical field and is called PLISSIT (Annon, 1976). As noted earlier, PLISSIT is an acronym that stands for Permission (P), Limited Information (LI), Specific Suggestions (SS), and Intensive Treatment (IT). I like this model in part because of the first construct, *permission*. This model teaches students to ask permission of their clients to address sexual health. It also allows the student to give themselves permission to ask about sexual health. Research indicates that addressing sexual health with clients can cause considerable discomfort for the clinician, in part because often they are concerned about making clients uncomfortable, fearful of using the *wrong* language, worried about imparting their own beliefs, or simply not having the correct information to provide to a client (Logie, Bogo, & Katz, 2015; Russell, Gates, & Viggiani, 2016). For all of these reasons and many others, clinicians shy away from addressing sexual health in practice. By reminding themselves (i.e., giving themselves permission) to ask a client's permission to address difficult topics such as sexual health, it can increase their own comfort level and decrease the need to be seen as an expert. Once permission is received from both the client and the clinician, the clinician can then proceed to gathering *limited information* (LI), providing *specific suggestions* (SS)—which may include reading, homework, and finding resources—or providing a referral for *intensive therapy* (IT) with a specialist, often a sex therapist. This model is one that is easy to remember and can be modified to almost any sexual health discussion. It allows for the student to step out of the role of expert and still discuss sexual health in a competent, effective, and comfortable manner. This model provides structure for beginning practitioners and can be applied to almost any population. Overall, students report the ease of remembering the acronym and also like that it takes the pressure off of them by not having to be an expert (the IT portion that includes referrals to other providers when needed).

In addition to including sexual health in professional training, I would be remiss if I did not include the need for future research on sexual health in professional practice. Little is known about what clinicians actually do in their clinical practice regarding sexual health, if they are comfortable addressing the topic, how they approach it, what interventions they use, and the outcomes of such interventions. By destigmatizing sexual health as a regular and normal part of human life, teaching it as a regular part of professional helping curricula can assist in addressing the multitude of sexual health problems clients encounter. Using a culturally humble approach—one in which a helping professional takes a place of curiosity and allows the client to be the expert in their knowledge and treatment of sexual health—is also an area to be further explored through research that can aid in the advancement of sexual health education.

Throughout my years of doing research and teaching, my views on sexual health have not changed dramatically. I still adamantly believe that all individuals in the helping professions need to be trained to discuss sexual health. While I enjoy teaching about sexual health, the number of students taking my Sexual Health in Professional Practice class who have prior sexual health education has not changed, and thus, the need to increase comfort levels of addressing sexual health in an open and empathetic manner have also not changed. Students and practitioners need to be not only educated on the basics of human sexuality but also receive on-going training to understand the influences of culture and social identities on sexual health, how their own values and attitudes toward sexual health can impede or enhance clinical relationships, and the need for skill-based training and evaluation to ensure ethical and effective treatment when sexual health concerns arise. Sexual health is an ever-changing construct that is impacted by a multitude of factors. While I never intended to study or teach sexual health, I believe it is an important part of human function, interactions, and the overall tapestry of life that must be addressed with each client in mental health and other health settings. Knowing how to do this in a respectful, skilled, and nonjudgmental manner takes time, a willingness to learn and make mistakes, and continued practice throughout one's career—mine included. I tell my students that while I teach sexual health and work to "practice what I preach," I am always learning from my interactions with others. I continue to work to be a culturally humble helping professional, teacher, and researcher who continually assesses my own comfort and effectiveness in addressing the ever-changing topic of sexual health.

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