MAIMONIDES UNIVERSITY

# IDENTIFICATION OF SEXUAL DISORDERS IN CLINICAL SETTINGS USING A BRIEF ASSESSMENT TOOL AND TRAINING PROGRAM

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**DISSERTATION APPROVAL**

This dissertation submitted by Krista A, Bloom has been read and approved by three committee members of the American Academy of Clinical Sexologists at Maimonides University.

The Dissertation Committee has examined the final copies and the signatures that appear here verify the fact that any necessary changes have been incorporated and that the dissertation is now given in final approval with reference to content, form and mechanical accuracy.

The dissertation is therefore is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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## VITA

Krista Bloom is a Licensed Clinical Social Worker, a Board Certified Clinical Sexologist, and a Board Approved Clinical Supervisor. She has over 17 years of experience in the social service field. She is currently in private practice in Plantation, Florida, specializing in sex therapy, individual and couples counseling, and clinical supervision. Krista promotes freethinking so that people may reach their highest potential, based on their needs, desires, and goals. She uses reality therapy and cognitive-behavioral approaches to help people to break old patterns of thinking and relating that block their happiness. Krista received her undergraduate training at Syracuse University in Child, Family, and Community Studies. She earned her Master's in Social Work at Loyola University of Chicago.

## ABSTRACT

This dissertation proposes a model for training social workers and other mental health professionals on how to assess for sexual disorders utilizing a new assessment tool, the Sexual Disorder Screening Questionnaire. Sex Researchers have documented the prevalence of sexual disorders over the past 50 years. At the same time, social workers and mental health practitioners tend to avoid discussing sexual concerns due to social stigma and lack of professional training on human sexuality. Relevant historical information and the shaping of social values about sexuality are discussed. The definitions and prevalence of sexual disorders are reviewed. Relevant assessment tools used to diagnose sexual disorders are evaluated. The need for a new brief assessment tool and training program is outlined. The rationale for specific questions on the Sexual Disorder Screening Questionnaire is provided and licensed social work and mental health practitioners evaluate the questionnaire. The training curriculum that teaches clinicians to identify sexual disorders utilizing a brief assessment tool is outlined. The training module is designed to enhance professional diagnostic competencies in the area of sexual disorders through reviewing sexual disorders, the importance of assessing sexual disorders, and ways that practitioners can utilize brief assessment in clinical settings in order to identify sexual disorders.

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# CHAPTER 1

## DEFINITIONS OF SEXUAL DISORDERS

The definitions of Sexual and Gender Identity Disorders utilized in this dissertation are taken from the most recent edition of the Diagnostic Statistical Manual for Mental Disorders, Fourth Edition, Text Revision (2000), which will be henceforth referred to as the DSM-IV-TR. The sexual disorders include Sexual Dysfunctions, Paraphilias, Gender, and Identity Disorders. The major sexual disorders described here are fundamental to the proposed training program and the Sexual Disorder Screening Questionnaire outlined in this dissertation.

One over-arching criteria for all of the sexual disorders per the DSM IV-TR is that the symptoms are persistent for at least six months, that they cause marked distress to the person involved and that they cannot be better categorized by another Axis I diagnosis (DSM-IV-TR, 2000). The six major categories of sexual disorders are sexual desire disorders, sexual arousal disorders, orgasmic disorders, sexual pain disorders, Paraphilias, and Gender Identity Disorders.

### Categories of Sexual Disorders

The first listed sexual disorders are the sexual desire disorders. Hypoactive Sexual Desire Disorder is described in the DSM IV-TR as a condition whereby a person is persistently or recurrently deficient or absent of sexual fantasies and desire for sexual activity. The next

listed sexual dysfunction is Sexual Aversion Disorder, which is categorized as a persistent or recurrent extreme aversion to and avoidance of all, or almost all, genital sexual contact with a sexual partner (DSM-IV-TR, 2000).

The next category of sexual disorders is Sexual Arousal Disorder. This includes the Female Sexual Arousal Disorder, which is a recurrent inability to attain or to maintain an adequate lubrication-swelling response of sexual excitement during sexual activity. Subsequently listed is the Male Erectile Disorder, which is a persistent or recurrent inability to attain or to maintain an adequate erection during sexual activity (DSM-IV-TR, 2000).

The next group of sexual disorders according to the DSM-IV-TR is the orgasmic disorders. Included is the Female Orgasmic Disorder, which is a persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase. There is also the Male Orgasmic Disorder, described as a persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase during sexual activity. Another sexual dysfunction that relates to orgasmic disorders is Premature Ejaculation, with persistent or recurrent ejaculation with minimal sexual stimulation before, during, on, or shortly after penetration and before the person wishes it (DSM-IV-TR, 2000).

The next category of sexual disorder is the sexual pain disorders. The DSM IV-TR defines Dyspareunia as recurrent or persistent genital pain associated with sexual intercourse in either a male or a female. Also included is Vaginismus, which is defined as recurrent or persistent involuntary spasm of the muscles of the outer third of the vagina, thus interfering with sexual intercourse. The final category of sexual disorder is the Sexual Dysfunction Not Otherwise Specified, which is defined as sexual dysfunctions that exist but do not meet criteria for any of the above Sexual Dysfunction (DSM-IV-TR, 2000).

## Paraphilias

The next category of sexual disorders is Paraphilias, which are defined by the DSM IV-TR as a person having recurrent, intense sexually arousing fantasies, sexual urges, or behaviors and causing significant distress or impairment in social, occupational, or other areas of functioning. The urges or behaviors within the paraphilias will generally involve nonhuman objects, the suffering or humiliation of oneself or one's partner, or children or other non-consenting persons. There are coercive and non-coercive Paraphilias. There is also a category for Paraphilias Not Otherwise Specified, which involves other unusual sexual behaviors (DSM-IV-TR, 2000). Although there are numerous types of Paraphilias, it is not necessary for the purpose of this dissertation to describe them in detail.

## Gender Identity Disorders

The final category of sexually related disorders in the DSM IV-TR is the Gender Identity Disorders, which involve strong and persistent cross-gender identification and a stated desire to be the other sex, to live as the other sex, or the belief the person has typical feelings and reactions of the other sex. There is also a persistent discomfort with their genital sex or a sense of inappropriateness in the gender role of that sex. The disturbance also causes clinically significant distress and impairment in major areas of functioning. This group of disorders can occur in childhood, adolescence, and adulthood (DSM-IV-TR, 2000).

Dr. Helen Singer Kaplan (1974) expounds upon the DSM concepts of sexual disorders by discussing factors associated with gender-specific sexual disorders in her book The New Sex Therapy. She distinguishes between the male-specific and the female-specific sexual disorders.

Kaplan describes the male dysfunctions and how often times these relate to some kind of sexual conflict. Kaplan discusses guilt, intra-psychic, and marital factors, which may contribute to the male sexual disorders. She also states that erectile dysfunction is the most common for males. Kaplan expresses that the female sexual dysfunctions are often mislabeled and misunderstood, and states that the causes of female sexual dysfunction can relate to psychological factors, history of trauma, marital problems. Kaplan states that the most common complaint from women relates to orgasmic dysfunction rather than Vaginismus or other sexual dysfunctions. Kaplan distinguishes between dysfunctions, healthy variations, and sexual Paraphilias she calls deviations (Kaplan, 1974). It is important to consider both the types of sexual disorders that people commonly experience, and the prevalence of such disorders within the population.

# CHAPTER 2

# LITERATURE REVIEW

## Prevalence of Sexual Disorders

The prevalence of sexual disorders in the United States was explored in groundbreaking research during the 1940's when Dr. Alfred Kinsey and his associates began to conduct nationwide sexual surveys. Kinsey identified that sexual difficulties were present within the population (Kinsey et al., 1949). Sexual disorders were later incorporated into the Diagnostic and Statistical Manual of Mental Disorders and were updated in later versions. Several major studies have been completed on human sexual behavior throughout the years that reinforce that sexual dysfunction is a significant problem for a large portion of the population; yet it is omitted from both assessment and treatment components of general social work and mental health counseling. This writer will discuss the results of some of the key surveys, and some of the factors the researchers proposed as underlying causes for sexual disorders. Kinsey et al. (1949) specifically studied erectile dysfunction among the 12,000 males they surveyed. In this, they found that for many of the males, their erectile abilities and erotic response decreased with age. Kinsey et. al. found that 115 subjects experienced impotence, or erectile dysfunction. Kinsey et al. describe unusual sexual behaviors, now known as Paraphilias, and the relatively small occurrence of these activities. They also discuss what is now termed premature ejaculation, but espouse it as more prevalent and relatively "normal". Kinsey et. al. state that males can learn to delay ejaculation, but that most would not find this to be desirable (Kinsey et al., 1949 580-581).

Kinsey et. al., in their book Sexual Behavior in the Human Female (1953), discuss in detail women's orgasmic incidence during various sexual activities, comparing marital, pre-marital, and extra-marital experiences. Their findings were that in any of the given study groups, that at least ten percent of the women they surveyed were unable to achieve orgasm by any means. Kinsey et. al. also postulate that most women can overcome this inability with some professional assistance or having positive experiences with partners (Kinsey et. al, 1953). Dr. Edward Laumann et. al. (1992) completed another significant study, which is known as the National Health and Social Life Survey conducted, which surveyed over 3000 men and women to study human sexual behavior. In one of their articles summarizing aspects of the research entitled Prevalence and Predictors In the Journal of the American Medical Association, Lauman et. al. discuss the prevalence of sexual dysfunction. According to the findings from this study, sexual dysfunction in this study was reported as forty three percent of females, and thirty one percent of males surveyed. According to Lauman and associates, sexual dysfunction is more likely among women and men with poor physical and emotional health. Moreover, sexual dysfunction is highly associated with negative experiences in sexual relationships and overall well-being. Lauman et. al. discuss that sexual dysfunction is an important public health concern, and emotional problems likely contribute to the experience of these problems (Laumann et al., 1992). One of the limitations of the study is in the sample population, which Lauman and associates did not include persons over the age of eighty, therefore lacking data and findings in that age group. Although none of these studies over time is all-inclusive, they do consistently indicate that sexual dysfunctions are prevalent within the population. Another staggering figure was reported by The National Institute of Health Consensus Statement from 1992 suggesting that the number of men in the U.S who suffer from erectile dysfunction specifically is ten to twenty

million, and that a majority of those clients were over the age of sixty five (National Institutes for Health, 1992). Nussbaum and Hamilton (2002) suggest that the prevalence of sexual dysfunction is as high as fifty three percent in males and sixty-three percent in females, citing studies completed by King, Specter, and Rosen. They also state that sexual problems have been reported in seventy five percent of couples who seek marital therapy (Nusbaum and Hamilton, 2002). According to Hatzichristou and associates (2004), more than two out of five adult women and one out of five adult men experience sexual dysfunction in their lifetime, under diagnosis occurs frequently. Hatzichristou and associates state that sexual problems are prevalent in men and women, yet frequently under-recognized and under-diagnosed in clinical practice even among clinicians who agree that addressing sexual problems is relevant (Hatzichristou et al., 2004). Despite these findings of the existence and prevalence of sexual disorders, sexuality as a topic has been viewed over time as controversial. Much of this is related to historical and social factors that have created taboos preventing people from discussing sexuality openly, which will be discussed next.

## Historical Context and Social Stigmas around Sexuality

Although the most current edition of the DSM-IV-TR describes and defines sexual disorders in detail, clinicians seem to be uncomfortable discussing sexuality with their clients. Kinsey, in his book Sexual Behavior in the Human Male (1949) notes the strong influence that religions have had on shaping persons attitudes and sexual behavior. He describes the history of Judeo-Christian traditions in this vein, and compares devout with non-observant persons. He discusses taboos that occur in Judeo-Christian religious philosophies, and states that although

religious institutions laws are no longer responsible for law enforcement directly; however, their morals and mores continue to influence people's perceptions on what is acceptable or perverse for people to engage in (Kinsey, 1949 465-487). Marca Sipski and Craig Alexander (1977), in their book Sexual Function in People With Disability and Chronic Illness; a Health Professional's Guide (1997), discuss the reluctance and inability of rehabilitation programs and professionals to provide sexuality assessment and counseling services. Sipski and Alexander cite multiple sources of documentation of poor preparation of most health care providers in the area of sexuality, such as (Cornelius et. al, 1982; Conine, 1984; Ducharme & Gill, 1990; Finger, 1993, Gender, 1992; Kempton & Kahn, 1991; Sawyer & Allen, 1993; and Straus 1991). Sipski and Alexander cite Eisenber & Rustad, (1976), who tout sexuality and disability as two of the major taboos in Western society. They state that rehabilitation professionals are a product of our society, which traditionally has viewed disable people as unable or disinterested in developing intimate relationships, or asexual. This can be applied to mental health professionals, who also work in various settings with physically and mentally disabled people. Sipski and Alexander also state that health care professionals continue to feel ill prepared to address sexuality issues with their clients, even though they are more aware now of the importance of sexuality issues to their clients. Sipski and Alexander cite a survey by Novak and Mitchell (1988), who found that when they surveyed 129 rehabilitation professionals, seventy-nine percent reported that sexuality was as important as other aspects of rehabilitation, but only nine percent felt comfortable addressing the issue of sexuality. In addition, only about half of the respondents addressed sexuality if the patient or family initiated discussion about sexuality. Furthermore, forty-one percent of Novak and Mitchell's respondents reported that they felt uncomfortable discussing sexuality issues because they lacked the necessary preparation and experience to address this

topic (Sipski and Alexander, 1997). Robert Crooks and Karla Baur (2005), in the ninth edition of their book Our Sexuality describe cultural values and religious mores, which have shaped social attitudes about sexuality from a psychosocial perspective. According to them, peoples' emotions, attitudes, motivation, social conditioning, expectations, and norms have a major impact on sexual attitudes, values, and behavior. Crooks and Baur also discuss the biology of sexuality and the importance of this on sexual behavior. They cite Beach who stated that each society structures and defines acceptable sexual behaviors for all people. In the case of Western culture, there have been some variations of thought related to sexuality, but there are some foundational ideas that continue to prevail. Crooks and Baur discuss the prevailing idea that procreation is the only legitimate reason for sexual behavior. They further explain that there are major performance pressures on women and men to respond sexually and orgasm solely during penetration. Crooks and Baur state that same-sex activity does not fit the model of sex for procreation, and that homosexuality and sexual behaviors outside of heterosexual coitus for reproduction have been seen over time in North American culture as immoral, sinful, perverted, or illegal, because they offer pleasure outside of procreation. They also examine various religious perspectives on human sexuality in the Western world, including Judaic and Christian traditions. According to Crooks and Baur, there was some ability to celebrate sexuality in Judaic tradition within the context of marriage. However, Crooks and Baur espouse that early Christians separated themselves from Judaism, Greek, Persian, and other religious belief systems by naming sex as sinful around sixty-six A.D. It was around this time, according to them, those persons who were celibate, or unmarried and abstinent from sexual intercourse obtained a higher social status. According to Crooks and Baur, church leaders continued to expand on the idea that sex was sinful. For example, Bishop Augustine stated that lust was the original sin of Adam and

Eve, and he secured the notion that sexual intercourse was only for procreation throughout his writings. Crooks and Baur also cite Weisner-Hanks, who discuss the concept that the only appropriate sexual position for intercourse is that of the man on top of the woman (Crooks and Baur, 2005, 9). Crooks and Baur state that the sex is a sinful belief dominated through the middle ages and the beginning of the Renaissance around 1400. According to them, there were heavy penances associated with sexual acts other than penile-vaginal intercourse for procreation. Some of the penalties for sexual behavior outside of intercourse for procreation were heavier than penalties for murder. Thus, there was great social pressure to conform to the beliefs and behaviors supporting sex as sinful. Crooks and Baur further discuss the concepts of sexuality throughout the Victorian Era, which polarized the roles of women between Madonna and whore, and the belief of the time was that women of a higher class did not have sexual desires or needs, but were responsible for home making. At this time prostitution flourished because of a prohibition of sexual companionship, even within the context of marriage. In addition, Crooks and Baur cite Ellison who discusses Celia Mosher, a physician during the 1800s that surveyed 47 married women over 30 years and found that despite cultural norms, most of the women experienced sexual desire and orgasm. Crooks and Baur discuss the exploitation and stereotyping of enslaved men and women in the 1800s, which was then used to justify and oppress them sexually and socio-economically. According to Crooks and Baur, these beliefs are still present and influential in Western culture. Crooks and Baur state there were some changes in ideology about sexuality in the twentieth-century, based on some major writings, the women's suffrage movement, the abolition of slavery, and more flexibility of gender roles around World War I. They also describe the rebellion of younger females, the flappers, who rejected Victorian mores and explored alternative sexual behaviors such as kissing and petting. However, Crooks

and Baur explain, during the depression era there was a return to more restrained behavior, and led to laws mandating the right of women to have access to contraception. During World War II, women had flexibility of gender roles. Later, they were expected to return to their homes and family duties. Crooks and Baur, cite Brown and Fee, explaining that around in the late 1940's and early 1950's Kinsey's sexuality studies were published, and were bestselling despite the medical profession, clergy, politicians and the media's negative remarks about his work. Crooks and Baur mention the contradictions of couples with separate beds in 1950s American television, and at the same time, the first Playboy magazine was issued. They further discuss the sexual revolution of the 1960's and 1970s, the development of the field of sexology, the legalization of contraception in all states by 1972, and the legalization of abortion in 1973. Crooks and Baur also discuss the increased social tolerance of varied sexual behavior, the variety of self-help books published about sexuality, and a positive attitude shift of more people toward gay and lesbian people for a time. According to them, the American Psychiatric Association removed homosexuality as a diagnosis from the DSM in 1973. Crooks and Baur state that with the onset of the first and subsequent cases of HIV and AIDS, there was a magnification of negative perceptions toward homosexual people, and that there have been increased incidences of violence toward gay and lesbian people. Finally, Crooks and Baur discuss that laws, policies, and norms are often fused in the area of sexuality, and that although since the 1960's and 1970's with the sexual revolution and the advent of sex therapy that some beliefs began to change, that the other beliefs are still rooted within our cultures and value systems. However, they state that social norms are often made into laws, and those support or interfere with a person's right to privacy and choice (Crooks and Baur, 2005, 19). Sipski and Alexander (1977) discuss how gender roles have significantly changed over the past forty years in terms of the increased

commonality and acceptance of single parenthood, serial monogamy, and pre-marital sex (Sipski and Alexander, 1997).

## The Stigma of Sexuality and the Omission of Sexual Questions in Assessment Tools

Although sexuality and the containment of sexuality has been a major force within a historical and cultural framework, psychosocial assessments do not usually include questions specifically related to sexuality or sexual disorders. On occasion, one may find sparse questions about a history of sexual abuse or perhaps sexual activity. William Masters and Virginia Johnson (1970), in their book Human Sexual Inadequacy, discuss a common mistake practitioners make in taking sexual history is seeing it as separate from a psychosocial history and therefore omitted. They state that during social surveys, sexually oriented questions are rarely used, and that one of the main reasons for this is a residual effects of Puritan ethics and underlying beliefs that sex is sinful. Consequently, sexual disorders are most commonly identified in the clinical arena when the clients themselves present to the clinician symptoms of sexual disorders; otherwise, sexual disorders can be overlooked (Masters and Johnson, 1970). Sipski and Alexander (1997) cite the lack of collaboration between psychologists, sex therapists, and physical health professionals inhibit the identification and treatment of sexual dysfunction in persons with disabilities that is often overlooked. Sipski and Alexander also discuss that disabled people are viewed as nonsexual beings, which is another reason why their sexual issues are often ignored (Sipski and Alexander, 1997). According to the Nusbaum and Hamilton (2002), some of the reasons practitioners are reluctant to discuss sexual history are as follows: embarrassment, feeling unprepared, a belief that sexual history is not relevant to the chief

complaint, and time limits. In addition, Nusbaum and Hamilton discuss that patients, too, report that physician discomfort or their perceptions that doctors will not be responsive to these concerns are one of the main barriers to discussing their sexual concerns. According to Nusbaum and Hamilton, some of the reasons for the omissions include a lack of specific training and expertise in sexuality or a socially prescribed belief that sexual questions are too personal or invasive (Nusbaum and Hamilton, 2002). Dr. Derek Polonsky (2001) cites Maurice who discusses the assumption that sexually related questions are experienced as invasive and inappropriate, and therapists worry about their clients responding negatively to such questions. In addition, Polonsky (2001) discusses the false belief that if a client has sexual concerns, he or she will raise them. Since shame and embarrassment are inhibitors, Polonsky did not find that his clients would be prone to initiate discussions regarding their sexual concerns. Polonsky cited the Ende research study, whereby over ninety percent of physician's patients who had a brief sexual history taken expressed that physicians initiating discussion of sexual issues was appropriate and relevant in a medical context. Polonsky also discusses that separating sexuality and sexual behavior is limiting because it removes sexual functioning from its natural context. Polonsky espouses that our society avoids open, direct talk about the subject of sex, and that mental health and medical practitioners have little formalized training about taking sexual histories or treatment alternatives (Polonsky, 2001).

Another factor related to the omission of sexual information when taking histories is that of ageism. On the theme of ageism, Polonsky (2001) states that younger therapists may identify their older clients with their parents, and will avoid sexual questions because they are reminded of their parents, whom they would prefer to think of as asexual. According to psychiatrists Walter Bouman and Jon Arcelus (2002), when taking a history, psychiatrists often avoid asking

questions about sexuality due to beliefs that older patients are not sexually active, despite research that clearly demonstrates sexuality across the lifespan, and conditions such as erectile dysfunction in men. Bouman and Arcelus (2002), state that middle-aged men are much more likely to receive proper assessment, referral, and treatment of sexual dysfunctions than are older men (Bouman & Arcelus, 2002). According to Barbara Levy (2002) in her article about breaking the silence of discussing sexual dysfunctions, sexuality has been a taboo subject among women and many physicians for a long time. Levy states there seems to be a new openness about sexual dysfunction emerging, and that practitioners can play a vital role in assessing for and treating sexual dysfunctions. Levy (2002) cites Marwick, who found that 71% of adults 25 and older believed their physician would dismiss any sexual concerns they might bring up, while 68% avoided discussing sexual dysfunction with their doctors for fear of embarrassing them. Levy further states that many doctors feel they lack the necessary background in fundamental science and psychology to evaluate and treat sexual complaints, and that it is difficult to approach sexual problems without a complete understanding the physiology and psychology of sexual response. She also states that the availability of Sildenafil to treat male erectile dysfunction has dramatically increased patients' awareness of sexual disorders, as has the open discussion of sexual dissatisfaction on talk shows. Levy states that patients are increasingly likely to expect their health-care providers to evaluate and treat sexual complaints (Levy, 2002).

Dr. Paul Abramson (1989) discusses that even though sexuality is a vital part of human existence, it is seen as an intrusive subject, and brings with it emotional and ethical complications which discourage scientific study of human sexuality. He discusses the dire consequences related to the lack of societal and scientific support for sexuality research, such as continued spread of sexually transmitted diseases and unwanted teenage pregnancy. According

to Abramson, scientists, researchers, and professors fail to prioritize human sexuality as a science, therefore severely limiting the knowledge base in this area (Abramson, 1989). According to the National Institutes of Health Consensus Development statement from the 1992 conference on impotence, a lack of information about sexuality to large segments of the population and practitioners' persistent unwillingness or inability to discuss sexual issues openly results in patients being denied treatment for their sexual concerns (National Institutes for Health, 1992). Levy (2002) states that although women are gradually opening up about sexual dysfunction, she does not assume that they will raise the subject themselves. Levy sites a study completed by Montejo et. al. who found that among 308 patients taking selective serotonin reuptake inhibitors (SSRI), 55% reported sexual dysfunction when the physician asked them about it directly compared with only 14% who reported it spontaneously. She continues to discuss other patient barriers, such as the fact that many women may not realize sexual complaints are an acceptable subject when accessing medical services, while others may feel uncomfortable talking about sex in general (Levy, 2002).

The assessment process is seen as vital in any clinical setting. Sexuality as a whole and sexual disorders specifically, because of the social factors and barriers described above, are omitted from the assessment process. Other areas of functioning are found on most standard psychosocial assessments. Assessments in inpatient and outpatient settings will often have sections for mental status, mood, behavioral concerns, suicidal ideation, substances, educational level, social history, occupational function, life stressors, and medical conditions. General assessments also usually include patterns of eating, sleeping, physiological symptoms (excluding those that are sexually related) and personality traits. It is a treatment standard in all mental health disciplines, to take a complete psychosocial history, in order to get an accurate picture of

what is happening at the time for the client, what physical and environmental factors exist that brought them into treatment. A review of books utilized in graduate training programs for social work demonstrate that sexual information and sexual disorders are minimized or omitted in the evaluation process. For example, Marilyn Zide and Susan Gray (2001) in their book Psychopathology, a Competency-Based Assessment Model for Social Workers, mention only one sentence in their book about sexual activity. Zide and Gray describe in detail other categories of disorders in the DSM, such as cognitive, mood, substance abuse, personality, dissociative, and eating disorders, but do not dedicate any chapters to sexual disorders. Edward Neukrug and Charles Fawcett (2006) in their book Essentials of Testing and Assessment: A Practical Guide for Counselors, Social Workers, and Psychologists, mention sexual satisfaction briefly. However, Charles and Fawcett discuss sexuality under a miscellaneous category if a client presents a situation such as sexual dissatisfaction. Other required foundation books, used by accredited social work programs, also do not address the sexual disorders in the assessment or treatment process. Lawrence Shulman (2006) in the fifth edition of his book The Skills of Helping Individuals, Families, Groups, and Communities, does not mention sexual disorders in the text. He discusses the phases of helping, including engagement and problem identification, but omits sexuality as an issue. Susan Lucas (2003), in her book Where to Start and What to Ask, an Assessment Handbook, includes childhood sexual abuse only in her discussion around sexuality issues (Lucas, 2003). Lucas does not cover assessing for sexual disorders.

Despite the social programming and stigma, that surrounds sexuality, there has been a movement by sexologists since the late 1940s, to include sexuality in the assessment process. Kinsey et. al. (1949), (1953), describe sexual behavior and concerns of males and females. They took a very detailed sexual history in their nationwide surveys (Kinsey et al., 1949, 1953).

Masters and Johnson (1970) expound upon the importance of taking a proper and complete history including background information, onset, severity and duration, and psychosocial effects of any presenting sexual dysfunction, as well as other psychosocial factors. Masters and Johnson discuss that a complaint of sexual dysfunction may reflect a client's psychopathology, or may be caused by lack of knowledge, unrealistic self-expectations about sexual function, or poor communication of partners about their sexual desires or inhibitors. In order to address this, they stress the importance of practitioners being unbiased in their approach, thus encouraging clients to be open and accurate when sharing information (Masters and Johnson, 1970). Dr. William Hartman and Marilyn A. Fithian utilize a bio-psychosocial approach to assessing and treating sexual dysfunction. According to Hartman and Fithian (1972), taking a sex history is one of the most important aspects in terms of diagnosis and treatment of sexual dysfunctions. According to Hartman and Fithian, a sex history will allow people to share those thoughts, feelings, activities and fantasies with another person in order to free their sexual minds and open communication with their partners. The Hartman and Fithian history combines several well-known instruments by Kinsey, Masters and Johnson, etc. and their own added questions. Hartman and Fithian reported that people from any generation tend to lack sexual information, and taking a sex history brings them to awareness that they are lacking this knowledge and helps to define problems and treatment goals. Their sex history is quite extensive, and can take from two to five hours to complete. Hartman and Fithian also discuss the importance of physical and psychological testing and other methods they utilize to gain information about their clients' conditions. For the purposes of this study, this history would not be realistic or feasible as a general assessment tool for the general population. Hartman and Fithian assessment process seems to be very inclusive and comprehensive in nature for someone who has sexual difficulties

or dysfunction, and would provide a sex therapist with a complete picture of a person's thoughts, feelings, and behaviors. One important point they make in the sex history chapter is that it is important to understand there is a wide range of sexual behavior that can be considered normal, and this can remove the sense of guilt or the stigma attached to sexual behaviors. Another important point Hartman and Fithian make is that the treating therapist should not impose their own morals or values on a client; but rather should try to normalize the behaviors the clients have and promote sexual functioning (Hartman and Fithian, 1972). According to physician Nancy Phillips (2000), in her article about diagnosis and treatment of female sexual dysfunction, many physicians feel unqualified to assess for or treat sexual dysfunctions. Phillips stresses that despite this, treating physicians should obtain a detailed patient history that defines the dysfunction, identifies causes or confounding medical conditions, and elicits psychosocial information. Phillips suggests using questionnaires or exclusive history-taking appointments to allow communication to be open and uninhibited (Phillips, 2000).

In 1992, The National Institutes of Health held a conference related to Erectile Disorder. The NIH Conference had a panel of experts, including sexologists, psychologists, and physicians that discussed prevalence, risk factors, and need for appropriate patient assessment related to erectile dysfunction. According to the committee, one of the concerns is that patients and practitioners are embarrassed about discussing sexual issues openly, which leads to under diagnosis of erectile dysfunction. According to the NIH Consensus Development Committee report (1992), the tendency for clients and practitioners to be embarrassed can also lead to under diagnosing of the other sexual disorders. According to the report, evaluations will include a sensitive sexual history taken via interview by a specially trained professional. The report states that the purpose of the sexual history is to determine whether a patient's complaint is related to

an erectile dysfunction, a desire disorder, an orgasmic disorder, or an ejaculatory disorder. According to the NIH report, psychosocial factors should be explored during evaluation (NIH Consensus Development Committee report, 1992). Another clinician who discusses the importance of taking a sexual history is Dr. Edward Zuckerman (1995) who wrote the Clinicians Thesaurus, the Guidebook for Writing Psychological Reports. This book covers all aspects of the DSM-IV, and recommends taking a detailed sexual history with over 100 questions and sub questions. Zuckerman also refers clinicians to works by Masters and Johnson (1970) and Kaplan (1983) for a more complete sexual history (Zuckerman, 1995). The Zuckerman shorter version of the sexual history is still quite lengthy and time prohibitive for most clinicians, and is designed for a complete psychological evaluation, which is beyond the scope of a general biopsychosocial assessment. Dr. Margaret Nusbaum and Dr. Carol Hamilton (2002) wrote a thought-provoking article about the importance of assessing sexual history and function as a part of responsible health care. Although they focused on physicians, the information is applicable to social work and mental health practitioners. According to Nusbaum and Hamilton, overall wellness considerations include addressing sexual dysfunctions and concerns in patients. Nusbaum and Hamilton report that physicians underestimate the prevalence of sexual health issues and concerns. They further state that discussing sexual health may reduce high-risk sexual behaviors and identify sexual problems. Nussbaum and Hamilton (2002) suggest that practitioners regularly and routinely ask sexual histories, and promote using a non-judgmental attitude in order to make it easier for patients to discuss sexual issues and functioning (Nusbaum and Hamilton, 2002). According to Levy (2002), a treating physician should be conscious of any biases he or she holds about certain sexual practices or preferences and should learn to listen to and discuss ideas and behaviors that conflict with these biases without displaying discomfort.

Levy states that when a patient begins to talk about their sexual functioning, the practitioner should have the time to focus and pay attention, rather than being distracted or hurried (Levy, 2002).

According to Hatzichristou and associates (2004), assessment and treatment of sexual disorders in men and women need to include patient-physician discussion, history taking (sexual, medical and psychosocial), referral (as needed), shared decision-making and treatment planning, and follow-up. Hatzichristou and associates propose these clinical guidelines for evaluation strategies in the treatment of sexual dysfunction. They made recommendations that are patient-centered and evidence-based based on the 2004 National Conference of collaboration for Erectile Disorder of 200 multidisciplinary experts from 60 countries (Hatzichristou et al., 2004).

## Review of Assessment Tools for Diagnosing Sexual Disorders

There are numerous instruments and approaches utilized for assessment and treatment of sexual disorders. There are comprehensive sexual or biopsychosocial histories, and condition-specific assessment tools measuring everything from sexual disorders to sexual satisfaction. Some practitioners utilize a multi-assessment approach in order to determine the nature, extent, and duration of sexual problems. It is important to review some of the specific sexuality-related assessment tools that have been used in the past and present for specific problems to evaluate if any of the existing measures would be practical for use by general practitioners who want to include assessment of sexual disorders in their assessment procedures. Two renowned sex researchers, William Masters and Virginia Johnson (1970), provide an in-depth assessment

framework in their book Human Sexual Inadequacy. They recommend using a history-taking outline that includes numerous questions about lifelong psychosocial history including the areas of sexual function and satisfaction. The Masters and Johnson sex history outline includes questions specific to orgasm, erectile/ejaculatory difficulties, difficulties with intercourse, and some open ended questions about sexual difficulties (Masters and Johnson, 1970 41-51). Although the Masters and Johnson history is quite detailed, and would be helpful to a sex therapy or other clients with presenting sexual problems, it does not inquire about all of the sexual dysfunctions. It is also very lengthy, and would not be practical for a general practitioner who is seeking basic information about a client's sexual function. One of the foremost experts in the field that has provided comprehensive review of sexuality-related measurement tools is Clive Davis et. al. (1998) who wrote a book entitled Handbook of Sexuality Related Measures. The authors discuss over 200 questionnaires, which are considered reliable and valid in the field of sexology. Davis et. al. discusses the difficulty of finding assessment instruments used in clinical and educational settings, and the need for more research and information in this area. More specifically, Davis et. al. catalog measures related to sexual function and sexual dysfunction, which will be the focus of this discussion as these are most relevant to this review. Davis et. al. discusses the Sexual Dysfunction Scale, developed by Marita McCabe, which has 348 items total in the areas of sexual problems, premature ejaculation, erectile problems, retarded ejaculation, orgasmic dysfunction, female unresponsiveness, vaginismus, and lack of sexual interest. This scale is very long and would be most useful for a sexologist or sex therapist who is working in depth with a client presenting with sexual difficulties. Davis et. al. also present the Golombok Rust Inventory of Sexual Satisfaction (GRISS), by John Rust and Susan Golombok, which is a brief 28-item Likert scale that measures the quality of sexual functioning within a relationship as

well as sexual satisfaction and dysfunction. However, this scale cannot be reproduced because it is under copyright, and requires a qualified practitioner or organization to purchase it, which would be a barrier in most clinical settings. The instrument also asks about sexual satisfaction, and failure to reach orgasm specifically during intercourse, which are extraneous questions for identifying sexual disorders. This tool would be impractical to incorporate into general intake psychosocial interviews. This scale was demonstrated in clinical trials to be a valid measure of the outcome of therapy, according to Davis. The next scale is the Segraves Sexual Symptomatology Interview by Kathleen A. Segraves, which is designed to determine erectile function, and would not be appropriate for female populations. Next was the Attitudes Related to Sexual Concerns Scale, by Patricia Barthalow Koch, which examines more in depth feelings and attitudes associated with specific sexual concerns. It is a 5-point Likert scale with 30 items. Davis and associates describe it as a research or clinical tool to assess attitudes for presenting sexual concerns and dysfunctions. This scale does not include all of the major dysfunctions, and therefore would not be relevant to use as a pre-screening assessment tool for the general mental health practitioner. There are numerous other tests and scales listed in the Davis book on sexual awareness, attitudes and behaviors. One well-known instrument listed is LoPiccolo's Sexual History Form (SHF), which is a self-report assessment containing 46 multiple-choice questions geared toward measuring overall sexual behavior and function. The instrument would be very helpful for sex therapists, but is too in-depth for a general practitioner to incorporate into an assessment and too time consuming for a practitioner who needs to assess all areas of functioning. Another scale included is the Derogatis Sexual Functioning Inventory; a 254-item scale examines sexual functioning, satisfaction, and general well-being. This scale is much too long and detailed to be practical for the general social worker or mental health professional. The

next instrument is the Sexual Function Scale by Marita McCabe, a 174-item scale about sexual history, attitudes, behavior, and satisfaction (Davis et. al., 1998). Many other scales in the Davis book cover a particular sexual dysfunction in isolation, and other sexual topics. However, none of these scales specifically covers all of the major sexual disorders. Hatzichristou and associates (2004) propose a brief screening tool as well as the use of more in-depth assessments for sexual dysfunction (Hatzichristou et al., 2004). The above instruments demonstrate that due to impracticality of the instruments reviewed, it would be beneficial to offer practitioners an easily accessible, simple to use, abbreviated screening instrument for sexual disorders to use as part of their psychosocial assessment process.

# CHAPTER 3

# METHODOLOGY

## Rationale for a Brief Assessment Tool for Assessment of Sexual Disorders

According to Nusbaum and Hamilton (2002), there are two ways of taking a sexual health interview, the abbreviated method and the in-depth approach. Nusbaum and Hamilton suggest that if the sexual history seems unrelated to the chief complaint, a few screening questions will be adequate. They did not specify which screening questions would be appropriate. Nusbaum and Hamilton state that a more extensive sexual history can be taken during future sessions as needed. According to Nussbaum and Hamilton, the sexual health inquiry is deferred in emergencies. They point out that asking, "What sexual concerns do you have?" implies that sexual concerns are usual and that it is common to discuss them. Nusbaum and Hamilton state that regardless of whether the sexual history is brief or in-depth, it provides an opportunity for preventive care (Nusbaum and Hamilton, 2002). Levy (2002) recommends utilizing a biopsychosocial model for assessing complaints. Levy focuses on four areas: physical, psychological, relational, and situational. Levy states that by utilizing these categories, she can address the complexities of patients' complaints and assess each component of sexual dysfunction in the DSM-IV classification (Levy, 2002). Levy does not recommend any specific psychosocial tool or instrument to utilize for this purpose.

Hatzichristou and associates (2004) discuss the benefits of utilizing screening instruments for initially identifying sexual disorders in medical settings. They propose a brief screening tool for physicians to use with male and female patients. The limitation of Hatzichristou and associates' instrument is that it does not address the presence of paraphilias. It does address the other dysfunctions. Hatzichristou and associates identified the need for an assessment process for sexual dysfunction in medical settings. They encourage adoption of a common management approach for sexual dysfunction. Hatzichristou and associates encourage practitioners and patients to participate in the process. They also condone having respected for patient ideas, feelings, expectations, and values, and the conditions can be seen from the patient point of view. Hatzichristou and associates also encourage practitioners to maintain a flexible and comfortable demeanor when taking patient histories (Hatzichristou et al., 2004).

Due to time constraints and training limitations of social workers and other mental health practitioners completing biopsychosocial assessments, this dissertation proposes that social workers and other mental health professionals utilize a brief assessment tool for sexual disorders as part of the evaluation process. The next section describes a new assessment tool and training program

# Proposed Model of a Sexual Disorder Screening Questionnaire Including Training Curriculum for Practitioners

Sipski and Alexander (1997) discuss the importance of utilizing sexuality-training programs in the rehabilitation environment with disabled persons. Sipski and Alexander review program and training models that have been selected for staff education regarding sexuality. Sipski and Alexander (1997) cite Cornelius and associates (1982), who suggest that the most effective training approach is one that combines training methods. For example, Sipski and Alexander state that it is important to build knowledge among staff about anatomy, and physiology through reading, lecture, and discussion. Sipski and Alexander also state that approaching attitudes, awareness, and comfort with sexual topics may not be feasible in a large group format. However, Sipski and Alexander encourage techniques that include desensitization activities with explicit materials, small group discussion, exploration of values and beliefs, using special assessment tools and exercises, and role-playing. Sipski and Alexander espouse that the instructor modeling, role-playing, and practice can cultivate skills in assessment and history taking (Sipski and Alexander, 1997). The intensive course Sipski and Alexander recommend for the development of a sexuality program within rehabilitation is beyond the scope of this dissertation, because it is designed for an organization that plans to implement a sexuality-based program over a period of months or even years. However, the skills training segment about the assessment and training components discussed by Sipski and Alexander are helpful in substantiating the design of the brief assessment model and training curriculum.

With consideration of the prevalence of sexual disorders, and the reluctance of practitioners to discuss sexual issues with clients, it is most feasible to utilize a brief screening instrument as a way to identify the existence of a sexual disorder in clients who present for

mental health services. As an approach to addressing these problems, a model is proposed that will encourage social workers and other mental health practitioners to incorporate a brief assessment tool for sexual disorders as defined by the DSM-IV-TR. This model consists of the Sexual Disorder Screening Questionnaire (See Appendix A) and a brief sexual disorder-training program for practitioners. The Sexual Disorder Screening Questionnaire consists of 12 questions, which relate to symptoms of 14 possible sexual disorders as outlined in the DSM-IV-TR (2000). The components of the training include an overview of sexual disorders, how to take a brief sexual history; how to overcome communication barriers; and how to identify specific sexual disorders using the Sexual Disorder Screening Questionnaire. The training incorporates practice and application activities to promote increased competency among social work and other mental health professionals. The training model also addresses ethical, legal, and referral concerns.

One of the main ways to determine the presence of a sexual disorder or disorders in an individual is by taking a thorough history of each client that seeks counseling services. The Sexual Disorders Screening Questionnaire could be utilized upon intake, as an attachment to the psychosocial assessment, much like a substance abuse screening tool or a depression inventory. The use of the Sexual Disorder Screening Questionnaire will allow practitioners to identify when symptoms of sexual disorders are presented. This will assist the practitioner in the treatment of the client, and in the referral process, if they are not trained or qualified to treat sexual disorders.

## Rationale for the Sexual Disorder Screening Questionnaire

Included in the screening instrument is a question for each major sexual disorder category. Each question begins with the phrase: "How often do you experience…" in order to frame each question in a way that encourages honesty by implying that these symptoms are common. A Likert 5-item scale is used so the respondent can rate their responses and to outline the severity of symptoms as follows: "Never, Occasionally, Sometimes, Often, or All the Time". This will inform the practitioner of the severity of the problem from the respondent's perspective. The Sexual Disorder Screening Questionnaire is designed for verbal administration during and interview tool. However, it could also be administered in writing with the presence of a practitioner for support and discussion purposes. Of concern is whether the Sexual Disorder Screening Questionnaire should be given in the beginning, the middle, or towards the end of the assessment interview. This author recommends incorporating the Sexual Disorder Screening Questionnaire into the latter part of the psychosocial interview, once basic rapport is established with the client.

The Sexual Disorder Screening Questionnaire (See Appendix A) begins with an introductory statement to acknowledge people's discomfort talking about sexual issues, and to convey reassurance to the respondent: "People are sometimes uncomfortable talking about their sexual experiences." The second phrase reads, "I want to reassure you that it is ok and important for us to talk about your sexuality in order to understand and address any sexual concerns you may have." The final introductory sentence conveys that the practitioner is available for questions or clarification: "Feel free to ask any questions if you need clarification about any of the questions I am going to ask you."

Each question in the Sexual Disorder Screening Questionnaire is selected based on containing symptoms of a specific sexual disorder as outlined in the DSM-IV-TR (2000). Each question is described in detail below.

Question one addresses whether the respondent has ever been sexually abused or coerced. This is relevant because it outlines when and how that person was sexually abused, which is a diagnostic code in the DSM-IV-TR (2000). The question reads, "Have you ever been sexually abused or coerced? Please describe what happened, how many incidents, with whom, etc." This will allow the respondent to discuss possible sexual abuse that has occurred.

Question 2 addresses the DSM-IV-TR disorder of Hypoactive Sexual Desire Disorder, with the main criteria being a person experiencing low levels of desire or no desire for sexual activities or fantasies. Question 2 reads, "How often do you experience low desire or no desire for sexual activity?" The respondent then determines how often they experience a lack of desire, giving the practitioner an indicator of the presence of a desire disorder in the client.

Question 3 discusses the DSM-IV-TR sexual disorder of dyspareunia, or genital pain during intercourse. The question reads, "How often do you have any pain in your genitals during sexual intercourse?" The respondent then determines how often they experience these symptoms, giving the practitioner an indicator of the presence of dyspareunia in the client.

Question 4 addresses the DSM-IV-TR disorder of gender identity disorders. It is seeking information from the respondent about whether they feel uncomfortable about their gender, or of being male or female. The question reads, "How often do you feel uncomfortable identifying with your gender (Being male or female)?" The respondent then determines how often they experience these symptoms, giving the practitioner an indicator of the presence of gender identity disorder in the client.

Question 5 addresses the DSM-IV-TR disorder of anorgasmia, or the inability of a person to reach orgasm during sexual activity. The question reads, “How often are you unable to reach orgasm during sexual activity, including masturbation, oral sex, or intercourse? This broader definition of sexual activity allows for a wider variety of healthy ways for a person to reach orgasm, which goes beyond a more limited definition of sexual activity, which historically focuses solely on intercourse as discussed previously by Crooks and Baur (2005). The respondent, by determining how often they have difficulty with reaching orgasm, gives the practitioner an indicator of the presence of anorgasmia.

Question 6 is designed to identify the DSM-IV-TR disorder of sexual aversion disorder, or a person who avoids mostly or entirely any form of sexual activity. The question reads, “How often do you find that you avoid sexual activity altogether?” The respondent then determines how often they experience sexual avoidance, giving the practitioner an indicator of the presence of sexual aversion disorder in the client.

Question 7 addresses the presence of the DSM-IV-TR disorders of paraphilias, which encompass disorders that include a person requiring a specific and unusual type of stimulation in order to experience sexual arousal and orgasm. Although there are numerous paraphilias, the question is framed in a general way, to be non-threatening to both the practitioner and the respondent. It does not list specific unusual behaviors that people might find offensive or upsetting, but rather asks, “How often do you engage in any sexual behaviors others might find unusual?” The respondent then determines how often they experience unusual sexual behaviors, giving the practitioner an indicator of the presence of paraphilias in the client.

Question 8 item a, is for males only, and addresses the presence of the DSM-IV-TR disorder of penile erectile dysfunction. The question reads, “How often do you have difficulty or

are you unable to have or maintain an erection?" The respondent then determines how often they experience difficulty having or maintaining erections. This gives the respondent and the practitioner an idea of the frequency of the problem for the person. Question 8-item b, is also for males only, and is designed to determine the presence of premature ejaculation. The question reads, "How often do you experience ejaculation before you wish to during sexual stimulation (shorter than 3-5 minutes)?" The respondent then determines how often they experience this inability, giving the practitioner an indicator of the presence of penile erectile dysfunction in the client.

Question 9 item a, is for females only, and is designed to identify the presence of the DSM-IV-TR disorder of vaginismus, whose primary symptom is involuntary spasms of the vagina. The question reads, "How often do you experience any persistent involuntary spasms of your vagina that interfere with sexual intercourse?" The respondent then determines how often they experience vaginal spasms, giving the practitioner an indicator of the presence of vaginismus in the client.

Question 9, item b, is for females only, and is designed to identify the presence of the DSM-IV-TR disorder of an arousal disorder, with the primary symptom of the woman's inability to attain adequate vaginal lubrication-swelling response during sexual activity. The question reads, "How often are you unable to attain an adequate lubrication-swelling response of sexual excitement in your genitals during sexual activity?" The respondent then determines how often they experience this inability, giving the practitioner an indicator of the presence of arousal disorder in the client.

Question 10 covers a requirement of all the DSM-IV-TR sexual disorders, which is that they cause the person marked distress or interferes with their relationships or other aspects of the

person's life. The question reads, "Do any of the above cause you marked distress, or interfere with your relationships or other aspects of your life?" There is blank space for the practitioner to record any responses given by the client.

Question 11 addresses whether the person's sexual disorder may be related to a medical condition the person experiences. The question reads, "If you answered that you experience any of the above: Did you notice your symptoms occurring at the same time as the onset of any medical conditions, medications or substances?" There is blank space for the practitioner to record any responses given by the client.

Question 12 covers any additional the DSM-IV-TR sexual disorders, not otherwise specified, or particular sexual concerns that the respondent might have. The question reads, "Do you have any other sexual concerns that I may not have mentioned? Please describe." This allows the respondent to express any issues they may not have expressed previously, such as sexual dissatisfaction, etc. There is blank space for the practitioner to record any responses given by the client.

## Training Curriculum for the Use of the Sexual Disorder Screening Questionnaire

The training program will include the following components: The Sexual Disorder Screening Questionnaire, a training outline, and several role-play exercises. The training will be completed on a one-time basis within 4 hours. The training covers an overview of sexual disorders, the prevalence of sexual dysfunction, training on administering the Sexual Disorder Screening Questionnaire, and practice exercises (see training curriculum, appendix B).

The first segment of the training will be a definition of sexual disorders. The second segment of the training will include the prevalence of sexual dysfunction, summarizing research to emphasize the significance of these disorders, and the importance of including this in our assessment, treatment and referral processes. The third section of the training is about assessing sexual disorders in the person-environment framework, briefly discussing barriers and cultural factors that often inhibit both practitioners and clients and prevent them from addressing sexuality in the assessment process. The fourth and final segment will provide an overview of the practical application of tools and curriculum in clinical settings. The focus of this section will be to determine when and how to utilize this instrument in practice.

The Sexual Disorder Screening Questionnaire can be used as part of any psychosocial assessment tool, in order to allow the practitioner to develop a more complete clinical picture of the client. One section of the training will also cover what to do once the client has identified that a sexual disorder or concerns that exist. Other options, such as completing a more in-depth assessment, referring the client out for a more in-depth assessment and/or treatment by a qualified, licensed, mental health professional with certification in clinical sexology will be discussed.

Ethical issues and concerns are discussed with the trainees, including the appropriate use of the Sexual Disorder Screening Questionnaire. For example, the training will cover that the Brief Sexual Disorder Screening Questionnaire is designed for use with persons of at least age eighteen years old. The training will also cover how to handle situations where the clients may refuse to discuss anything of a sexual nature because it is against their cultural or religious beliefs. It is important for the practitioner to understand and respect the client's refusal, and to leave the door open by telling the client that they can always bring up the issue later if they

change their mind. Sometimes, a person may be willing to share sexual information later in the therapeutic process, once they trust the practitioner. Practitioners will be given the option of re-administering the questionnaire when the client is more comfortable with discussing sexuality issues and rapport has been further established.

## Validating the Sexual Disorder Screening Questionnaire

In order to verify that the Sexual Disorder Screening Questionnaire is a useful tool for the identification of sexual disorders, at least 25 licensed clinical social workers or mental health practitioners will review the questionnaire through the Practitioner Evaluation Survey (see Appendix B).

**Methodology**:

1. The Sexual Disorder Screening Questionnaire, along with the evaluation survey of the Sexual Disorder Screening Questionnaire, will be given to a sample of at least 25 practitioners in person or via e-mail, with the participants permission.
2. The evaluation survey intends to be qualitative in nature, in order to improve the quality of the instrument through practitioner feedback.
3. The evaluation survey will be returned to this writer, who will then incorporate the findings into the body of the dissertation.
4. This writer will then make any necessary changes to the instrument, and propose the changes to the committee for approval.

**Practitioner Evaluation Survey Components and Findings:**

The Practitioner Evaluation Survey obtains qualitative feedback from licensed practitioners regarding the Sexual Disorders Screening Questionnaire. The structure of the survey instrument, the questions, and the responses from the participating practitioners are outlined below.

The introduction includes identification of the evaluator, and the purpose of the survey. The statement reads, "This survey is intended to evaluate a brief assessment tool, called the Sexual Disorder Screening Questionnaire (See attached). The Sexual Disorder Screening Questionnaire was developed to help licensed practitioners screen for sexual disorders in clients who present for counseling; to be included with a psychosocial evaluation for adult clients."

Of the two hundred practitioners requested to participate in the survey, twenty-seven responded successfully by reviewing the Sexual Disorder Screening Questionnaire and completing the Practitioner Evaluation Survey. The demographics of the survey respondents are as follows: two physicians, including one psychiatrist; one psychologist, ten mental health counselors; ten social workers; two marriage and family therapists, one sexologist and one gave no response.

The instructions are included for the respondents to complete the survey. The paragraph reads, "Please take some time to read and answer each question. Write in your responses to each question. Be as honest as you can in your responses. Your feedback is very important to this project". The final sentence informs the practitioners that their names remain confidential. The sentence reads, "Your identity will remain confidential." The demographics requested are limited to the practitioner's name and credentials, as this is the only necessary information for

this survey. Each question in the survey elicits feedback from the practitioners about their experience of the survey, and if the survey would be useful in their practices.

Question one reads, Were the questions on the Sexual Disorder Screening Questionnaire straightforward and easy to understand? The respondent checks yes or no, and there is space provided for the respondent to write an explanation after the phrase "Please explain". The first question is designed to measure if the language in the questionnaire is easy to understand, and thus user friendly. Twenty-six respondents answered "Yes"; and one respondent answered "No".

Question two reads, "Would the questions on the Sexual Disorder Screening Questionnaire help me to identify sexual disorders in clients presenting for counseling services?" and the respondent indicates yes or no. There is space provided for the respondent to write an explanation after the phrase "Please explain". This question is designed to ascertain if a practitioner would find the Sexual Disorder Screening Questionnaire useful in identifying sexual disorders, which is the main purpose of the questionnaire. Twenty-two respondents answered "Yes" to question two, indicating that the Sexual Disorder Screening Questionnaire would help them to identify sexual disorders in clients. Two respondents answered "No", indicating the Sexual Disorder Screening Questionnaire would not be useful in identifying sexual disorders. Three responses were other than "Yes" or "No".

Question three reads, "Would the Sexual Disorder Screening Questionnaire be a useful tool as part of a psychosocial assessment for your adult clients needing counseling services?" and the respondent indicates yes or no. There is space provided for the respondent to write their responses after the phrase "Please explain". Twenty-one respondents answered "Yes", indicating that the Sexual Disorder Screening Questionnaire would be a useful tool as part of a psychosocial assessment for their adult clients. Four answered "No", indicating the Sexual

Disorder Screening Questionnaire would not be a useful tool as part of a psychosocial questionnaire. Two responses were other than “Yes” or “No”.

Question four reads, “With whom would you use the Sexual Disorder Screening Questionnaire? The respondent checks off whether they would use it with “No Adult Clients”, “Some Adult Clients”, or “All Adult Clients”. There is space provided for the respondent to write their responses after the phrase “Please explain”. This question is designed to ascertain if practitioners would be willing to use the Sexual Disorder Screening Questionnaire with their own adult clients. Ten respondents answered they would use the Sexual Disorder Screening Questionnaire with “All Adult Clients”; sixteen answered they would use it with “Some Adult Clients” and one response was other than the options provided.

Question five reads, “What do you find most helpful about the Sexual Disorder Screening Questionnaire?” There is space provided for the respondent to write their responses after the phrase “Please explain”. Twenty-one of the twenty-seven respondents provided explanations to their response for this question. Responses to question five can be found in the written response section.

Question six reads, “What changes would you recommend making to the Sexual Disorder Screening Questionnaire to improve it?” and provides space for the respondent to write their responses after the phrase “Please explain”. This question is designed to receive qualitative feedback for improvement of the Sexual Disorder Screening Questionnaire itself. Twenty-three of the twenty-seven respondents provided thoughts and suggestions about the questionnaire. Responses to question six can be found in the written response section.

Question seven reads,” Would you need additional training in order to be comfortable administering the Sexual Disorder Screening Questionnaire?” The respondent checks yes or no,

and there is space provided for the respondent to write an explanation after the phrase "Please explain". The responses to this question could support the perceived need of practitioners for further training in the area of assessing for sexual disorders, and the benefit of the proposed training component discussed in this dissertation. Six respondents answered "Yes"; nineteen answered "No" and two responses were other than "Yes" or "No". Responses to question seven can be found in the written response section.

Question eight reads, "What other thoughts or feedback do you have about the Sexual Disorder Screening Questionnaire? This open-ended question allows respondents to provide any additional feedback they have about the Sexual Disorder Screening Questionnaire. Fifteen of the twenty-seven respondents provided explanations to their response for this question. Responses to question eight can be found in the written response section. The final statement in the practitioner evaluation survey thanks the participant and provides contact information of the author.

**Changes to the Sexual Disorder Screening Questionnaire because of the findings:**

Due to a suggestion between at least two participants, it will be beneficial to offer further explanation for the terms "lubrication and swelling response" on question one. As a result, this writer will add the words "vaginal wetness and vaginal swelling" in parentheses after the phrase "lubrication and swelling response".

The majority of respondents (twenty-five out of twenty-seven) among the professional group surveyed stated that the Sexual Disorder Screening Questionnaire would be helpful in identifying sexual disorders among clients presenting for counseling. There were concerns

expressed that deserve consideration. One issue was raised about the instrument seeming too short can be addressed by the fact that the Sexual Disorder Screening Questionnaire is a screening instrument and does not intend to replace an in-depth sexual history or psychosocial assessment. In response to the concern that the questionnaire focuses on too many areas, it is designed to touch upon all of the major sexual disorders as defined in the DSM-IV-R (DSM-IV-R, 2000). Although the Sexual Disorder Screening Questionnaire may not be appropriate in all settings, due to agency guidelines or assessment protocols, it may be helpful in many settings. It may be used in conjunction with any existing tools, for those clinicians or organizations who are interested in screening their clients for sexual disorders.

One of the themes that presented in question two was whether clinicians would find the Sexual Disorder Screening Questionnaire helpful in completing a psychosocial assessment of clients. As discussed in the research findings of Kinsey, Sipski, etc., clinicians would often not feel comfortable asking questions of a sexual nature, and would not approach the subject unless the client initiated the conversation. However, due to social stigma and taboo mentioned earlier, the client is likely to feel the same amount of apprehension and feel reluctant to discuss sexual issues. Consequently, the issue is likely to be, in these instances, overlooked altogether, unless either the clinician or the client overcomes the barriers that prevent the discussion of sexuality. If there is a sexual concern, it will remain unaddressed unless the practitioner opens the door of communication about sexual issues. There was some concern that clients may not be honest in their responses to survey questionnaires; however, non-disclosure is more likely to be a product of the client's inhibitions about talking openly about sexual issues then about the questionnaire itself.

# CHAPTER 4

# CONCLUSIONS AND RECOMMENDATIONS

It is important to recognize that identifying sexual disorders in the population of people seeking counseling services. Sexual disorders are often overlooked because of the stigma and bias that is the legacy of Western and other cultures discussed in this dissertation. Even when sexual difficulties are asked about and presented, the clinician may not have the specific skills or training needed to help the clients in that area. Clinicians also may not have the knowledge of how to refer their clients to specialized therapists for appropriate treatment if the client identifies having sexual disorders. These attitudes of uncertainty, discomfort, and lack of training and experience are reflected in the qualitative research findings.

It is evident among the respondents, and the lack of required sexuality education, that there is more training and education needed among clinicians of the healing arts. The cultural stigmas around sexuality that Kinsey et al. (1949), Sipski and Alexander (1997), Crooks and Baur (2005) and others persist in today's world. As with any other physical or mental disorder is necessary to assess for it, and to either rule out its existence or to identify it and treat it as a clinician would with any other disorder. Otherwise, it is a missing piece of the clinical picture. Clinicians are trained to examine the complex personal and social dynamics in the world. According to Phillips (2000), it is important to obtain a complete patient history, conduct a physical examination, apply of basic treatment strategies, providing patient education and reassurance, and recommend appropriate referral when indicated (Phillips, 2000). Practitioners

would benefit from addressing and overcoming their discomfort with discussing sexuality issues with clients, in order to provide appropriate identification, treatment, and referral of services. Training on the topic of sexual disorders, including teaching practitioners how to screen for sexual disorders can begin to fill in the gaps and assist practitioners in overcoming their own fears and reluctance to ask questions about sexual functioning. Once practitioners take this step, they can consider incorporating the Sexual Dysfunction Screening Questionnaire into their psychosocial assessment practices. Once sexual disorders are identified, clients can be treated or referred out for necessary services to qualified physicians and/or clinical sexologists. There is an opportunity for practitioners to cross-refer, based on their specialties and expertise.

Human sexuality is a very important aspect of the human experience. Human sexuality curriculum could be incorporated into all graduate level courses for practitioners who are to be treating mental health disorders, so that clinicians have the opportunity to respond to all human needs and mental health issues in clinical settings. As Hatzichristou and associates (2004) recommend, human sexuality and sexual medicine courses in health science curriculums are of great value (Hatzichristou et al., 2004). The same applies for social services and mental health fields. As of today, human sexuality courses are electives at the graduate level for social work programs. One of the directions to explore is interdisciplinary discussion and training around sexual disorders. Sharing information, offering trainings at conferences and other professional meetings can enhance and expand the knowledge base among social workers, and other physical and mental health professionals. With the high reported prevalence of sexual disorders, it seems clinicians can be even more helpful to their clients through adding a simple screening instrument such as the one described to help them to identify sexual disorders. As appropriate, the clinician

can then do further testing and evaluation, treat the sexual disorder, or refer the person or couple to a qualified specialist who can effectively address sexual disorders.

# APPENDICES

## APPENDIX A

Sexual Disorder Screening Questionnaire

As part of taking your history, I am going to ask you some specific questions about sexuality. People are sometimes uncomfortable talking about their sexual experiences. I want to reassure you that it is ok and important for us to talk about them in order to understand and address any sexual concerns you may have. Feel free to ask any questions if you need clarification about any of the questions I am going to ask you.

1. Have you ever been sexually abused or coerced? Please describe what happened, how many incidents, with whom, etc.

| |
|---|
| |

2. How often do you experience low desire or no desire for sexual activity?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| □ Never | □ Occasionally | □ Sometimes | □ Often | □ All the time |

3. How often do you have any pain in your genitals during sexual intercourse?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| □ Never | □ Occasionally | □ Sometimes | □ Often | □ All the time |

4. How often do you feel uncomfortable identifying with your gender (being male or female)?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| □ Never | □ Occasionally | □ Sometimes | □ Often | □ All the time |

5. How often are you unable to reach orgasm during sexual activity, including masturbation, oral sex, or intercourse?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| □ Never | □ Occasionally | □ Sometimes | □ Often | □ All the time |

6. How often do you find that you avoid sexual activity altogether?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| □ Never | □ Occasionally | □ Sometimes | □ Often | □ All the time |

Sexual Disorder Screening Questionnaire page 2

7. How often do you engage in any sexual behaviors others might find unusual?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| □ Never | □ Occasionally | □ Sometimes | □ Often | □ All the time |

8.a (For males only)
How often do you have difficulty or are you unable to have or maintain an erection?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| □ Never | □ Occasionally | □ Sometimes | □ Often | □ All the time |

8.b (For males only)
How often do you experience ejaculation before you wish to during sexual stimulation (shorter than 3-5 minutes)?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| □ Never | □ Occasionally | □ Sometimes | □ Often | □ All the time |

9.a (For females only)
How often do you experience any persistent involuntary spasms of your vagina that interfere with sexual intercourse?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| □ Never | □ Occasionally | □ Sometimes | □ Often | □ All the time |

9.b (For females only)
Are you unable to attain an adequate lubrication-swelling response of sexual excitement in your genitals during sexual activity?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| □ Never | □ Occasionally | □ Sometimes | □ Often | □ All the time |

10. If you answered that you experience any of the above:

Did you notice your symptoms occurring at the same time as the onset of any medical conditions, medications or substances?

| |
|---|
| |

11. Do any of the above cause you marked distress, or interfere with your relationships or other aspects of your life?

| |
|---|
| |

12. Do you have any other sexual concerns that I may not have mentioned? Please describe.

| |
|---|
| |

Appendix B

Practitioner Evaluation Survey of the Sexual
Disorder Screening Questionnaire

My name is Krista A. Bloom. I am a doctoral candidate in clinical sexology in the Clinical Sexology Department at Maimonides University, North Miami Beach, Florida. Thank you for participating in this professional survey.

This survey is intended to evaluate a brief assessment tool, called the Sexual Disorder Screening Questionnaire (See attached). The Sexual Disorder Screening Questionnaire was developed to help licensed practitioners screen for sexual disorders in clients who present for counseling, to be included with a psychosocial evaluation for adult clients.

Please take some time to read and answer each question. Write in your responses to each question. Please be as honest as you can in your responses. Your feedback is very important to this project. Your identity will remain confidential.

Your Name: _____
Credentials: (Licensure Type) _____

1.

1. Were the questions on the Sexual Disorder Screening Questionnaire straightforward and easy to understand? ❒ Yes ❒No

Please Explain:

| |
|---|
| |
| |
| |

2. Would the questions on the Sexual Disorder Screening Questionnaire help you to identify sexual disorders in clients presenting for counseling services? ❒ Yes ❒No

Please Explain:

| |
|---|
| |
| |
| |

3. Would the Sexual Disorder Screening Questionnaire be a helpful tool to use as part of psychosocial assessment for adult clients needing counseling services? ❒ Yes ❒No

Please Explain:

| |
|---|
| |
| |

Survey of the Sexual Disorder Screening Questionnaire page 2

4. With whom would you use the Sexual Disorder Screening Questionnaire?
❒ No adult clients
❒ Some adult clients
❒ All adult clients

Please Explain:

| |
|---|
| |
| |
| |

5. What you found most helpful about the Sexual Disorder Screening Questionnaire:

| |
|---|
| |
| |
| |

6. What changes would you recommend for the Sexual Disorder Screening Questionnaire?

| |
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| |
| |
| |

7. Would you need additional training in order to be comfortable administering the Sexual Disorder Screening Questionnaire? ❒ Yes ❒No

Please Explain:

| |
|---|
| |
| |
| |

8. Other thoughts or feedback about the Sexual Disorder Screening Questionnaire:

| |
|---|
| |
| |
| |

Thank you for your time and for participating in this survey. I welcome your feedback. Please feel free to contact me at thinkandfeelfree@yahoo.com.

## Appendix C

## Training Curriculum Outline

I. Overview

II. Definitions of Sexual Disorders

III. Prevalence of Sexual Disorders in Research

IV. Cultural Taboos that Prevent Open Discussion with Clients

V. The Importance of the Area of Sexuality in the Person-Environment Framework Assessment Process

   a. Introduction of the Sexual Disorder Screening Questionnaire

   b. Step by Step Administration of the Sexual Disorder Screening Questionnaire

   c. Role Play Exercise for the Sexual Disorder Screening Questionnaire

VI. Ethical Issues

VII. Closing Questions and Discussions

## Appendix D

### Step by Step Practitioner Administration of the Brief Sexual Disorder Screening Questionnaire

1. Introduction of the instrument. As in all other sections of an assessment tool, practitioners will prepare the participant that they are going to ask them questions related to sexuality.
2. Practitioners are informed that at the top of the questionnaire instrument is a sentence that practitioners can use verbatim that reads as follows: "As part of taking your history, I am going to ask you some specific questions about sexuality. People are sometimes uncomfortable talking about their sexual experiences. I want to reassure you that it is ok and important for us to talk about them in order to understand and address any sexual concerns you may have. Feel free to ask any questions if you need clarification about any of the questions I am going to ask you. "
3. Next, the practitioner is instructed to ask each question verbatim, by itself, and to allow ample time for the client to respond and elaborate as needed.
4. The practitioner is instructed to clarify any questions that the clients have about terminology, and to reassure them that their identified issues can be addressed.
5. The practitioner is informed that clients often have strong emotional responses to issues such as sexual trauma that may have occurred, or shame about unusual sex practices they may engage in.

6. The importance of practitioners conveying genuine acceptance of clients is emphasized in this section of the training.

**ALLOW Method for Assessment of Sexual Disorders**

Hatzichristou and associates (2004) suggest a useful acronym for assessment and treatment planning for practitioners that will be utilized in the training. This model can be utilized for a general framework in approaching identification of sexual disorders. Below are the steps Hatzichristou and associates identified.

Step 1: A=Ask the patient about sexual function

Step 2: L=Legitimize; accepting, acknowledging that sexual dysfunction is a relevant clinical issue

Step 3: L-Limitations → Refer out as needed

Step 4: O=Opening up the discussion

Step 5: W=Working Together to identify goals and treatment plans (Hatzichristou et al., 2004).

Appendix E

Role Play Exercise

Mutual Role Play exercises for practice purposes: This exercise will involve training participants to administer the instrument to clients by practicing on one another in pairs. This exercise has several purposes: The first is to raise awareness among practitioners about any difficulties they may have in asking clients sexually oriented questions so they can work to overcome barriers. The second is to be on the receiving end of the questionnaire to facilitate practitioner empathy with the clients they serve. The third is to practice administering the tool in a safe environment where they can receive feedback and will be able to improve your ability to administer the questionnaire correctly in the practice environment.

1. Each participant will have the opportunity to practice administering the instrument completely twice.
2. Each participant will have the opportunity to respond to the questions on the instrument twice.
3. The person who is role playing the practitioner will introduce the instrument and ask the questions as outlined.
4. The person who is role playing the client will choose a hypothetical sexual disorder that they suffer from to some degree and will reveal that to the practitioner

5. Once the role-play is complete, the pairs will discuss how the process was for them, what was most difficult for them, and what they could improve upon. It is important for both to provide feedback about the interaction.
6. The group will then discuss what was most meaningful in terms of learning for each pair. The trainer will have the opportunity to provide feedback and educational information to the group about any presenting factors in order to facilitate improvement of administration.
7. The pair then switches roles, and completes the instrument.
8. The person who is role playing the practitioner will introduce the instrument and ask the questions as outlined.
9. The person who is role playing the client chooses a hypothetical sexual disorder that they suffer from to some degree and will reveal that to the practitioner.
10. Once the role-play is complete, the pairs will discuss how the process was for them, what was most difficult for them, and what they could improve upon. It is important for both to provide feedback about the interaction.
11. The group will then discuss what was most meaningful in terms of learning for each pair. The trainer will have the opportunity to provide feedback and educational information to the group about any presenting factors in order to facilitate improvement of administration.

Appendix F

Detailed Written Responses from the
Practitioner Evaluation Survey

The following are the more detailed responses of the twenty-six practitioners who responded to the Practitioner Evaluation Survey.

On question one of the Practitioner Evaluation survey “Were the questions on the Sexual Disorder Screening Questionnaire straightforward and easy to understand?” eight respondents said the questions were very clear and easy to understand. Two responded simply “Yes”. Two respondents suggested clarification for the phrase “lubrication and swelling response.” One respondent suggested the following amendment of question one as follows: “The question have you been sexually abused or coerced could be phrased in a way that might get more information "when was your first sexual experience, was it voluntary or wanted, you could say how old were you, some clients may be confused about abuse or coercion because of other physical factors.” One respondent suggested clarification for question one as follows: “could be more specific, i.e. orgasm during intercourse and masturbation are two very different things. One respondent stated they would only ask “Yes” or “No”, and then verbally ask for details. One respondent stated the questionnaire is too short. The unedited responses are as follows:

- I would only ask yes or no, then verbally ask for details. I think people would have trouble writing it all down.
- Each question was fairly easy to understand, the wording used everyday language for the most part
- Yes

- The question have you been sexually abused or coerced could be phrased in a way that might get more information "when was your first sexual experience, was it voluntary or wanted, you could say how old were you, some clients may be confused about abuse or coercion because of other physical factors
- I think the questionnaire is too short
- Yes
- There were not any questions that I did not understand.
- Worded in clear language and easy to understand
- They were direct and to the point
- Overall, they were clear
- Yes, but could be more specific, i.e. orgasm during intercourse and masturbation are two very different things
- Easy language
- I thought most of the questions were easy to understand. However, 9a and 9b might be a little confusing to a client due to the words “swelling response” and “involuntary spasms.” I can imagine being asked to explain those terms.
- Yes, but I wonder if the phrases "persistent involuntary spasms" and "adequate lubrication-swelling response" will be clear to everyone
- The questions were straightforward and easy to understand.
- Very easy language used, not overly clinical

For question two of the Practitioner Evaluation Survey “Would the questions on the Sexual Disorder Screening Questionnaire help you to identify sexual disorders in clients presenting for counseling services?” sixteen of the twenty-seven respondents provided explanations to their

response for question two. Five respondents stated “Yes” in the explanation section. Five respondents indicated the Sexual Disorder Screening Questionnaire would be helpful in some degree; two felt the questionnaire would be helpful, however “honesty on the subject is difficult and may not happen”. The final four responses about the usefulness of the Sexual Disorder Screening Questionnaire included that the questionnaire “focuses on too many areas”, “I work with incarcerated sexual offenders”, “the questions were very specific“; and the questionnaire was “too short”. The unedited responses are as follows:

- Quite possibly it would but I've never used the questionnaire in practice so I'm uncertain how it would actually work
- Somewhat yes but not necessarily
- Yes, but again, is too short
- No, it focus on too many areas: trauma, medical, preferences
- Questions were straight forward, but I also think honesty is going to be a huge factor. Good idea, maybe that client completes on own time, then brings it back into you to discuss
- The questions were very specific
- I believe they would certainly induce a dialogue by attacking the taboo of the subject head on and making the client feel comfort to discuss an "uncomfortable" topic. Even if the client did not feel comfortable answering completely honestly in the first session, the questions being broached would make them think. In addition, once trust was better established, they would know what discussing such symptoms and its relations to the "resenting problem' would be safe with you.

- The answers to the questions would provide the basis for the therapist to further explore symptoms to determine if there was a sexual disorder or some other psychological factors at work, or whether there has been abuse and its effects particular on sexual functioning
- I assume this is to be used orally rather than as a written instrument. This would allow further explanation of questions if necessary. It would help identify areas that need further discussion, explanation, etc.
- Yes, however, honesty on the subject is difficult and may not happen
- All depends on what the client considers normal or "usual"
- Absolutely
- Yes I'm sure that they would
- To some degree
- I work with incarcerated sexual offenders
- Maybe not identify, but certainly it would narrow the field

For question three of the Practitioner Evaluation Survey, “Would the Sexual Disorder Screening Questionnaire be a helpful tool to use as part of psychosocial assessment for adult clients needing counseling services?” sixteen-responded yes and ten responded no. Fourteen respondents added an explanation to their “yes” responses as follows: Five respondents who answered yes with an explanation indicated they would only administer the questionnaire after an initial assessment and rapport building with the client. Four respondents referred to clinicians administering the questionnaire only if the client raised the issue of sexual disorder; three respondents indicated the usefulness of the Sexual Disorder Screening Questionnaire as part of their assessment and practice procedures. Two clinicians indicated they would need training prior to administering the questionnaire. Four of the respondents wrote yes without additional

comments. Comments about building rapport prior to administering the questionnaire included: “Patients may not be completely honest; they exaggerate, deny or undermine certain problems. Especially if they are not comfortable with the questions. Can the assessment target the presenting problem of the client? Once the client states the primary purpose of the visit?”; “No, I wouldn't ask these questions without rapport first”; “I’m not sure that all adults would feel comfortable answering these questions as part of the initial process, but, maybe, after developing rapport. I think that all couples coming in for sex therapy and maybe couples counseling would benefit from answering these questions initially.”; “It would be too uncomfortable for them. I would include a couple of general questions (e.g. do you have any sexual concerns or dissatisfaction with your sex life? If so, I would give the questionnaire” and “However expectations of immediate response or "truthful" answers at first may not be realistic. In other words, the benefits of seeking this information in an effort to better understand and help the client may take some time- to get the whole true picture”. The comments for using the questionnaire as part of the assessment and practice include, “Yes, I think so. Again, the nature of the questions allows for clinician to gain some insight into potential areas of importance with regards to sexual difficulties, past or present.”; “I assume this is to be used orally rather than as a written instrument. This would allow further explanation of questions if necessary. It would help identify areas that need further discussion, explanation, etc.” and “As part of a comprehensive interview”. The unedited responses are as follows:

- It would be too uncomfortable for them. I would include a couple of general questions (e.g. do you have any sexual concerns or dissatisfaction with your sex life? If so, I would give the questionnaire.

- I am unsure; I would have to have better knowledge of how it is scored and what the responses indicate. We do not normally think of sexual disorders as a component of the psychosocial assessment, but we really should include it.
- Yes
- As part of a comprehensive interview
- Yes
- No not unless the presenting problem is sexual
- Yes, I think so. Again, the nature of the questions allows clinicians to gain some insight into potential areas of importance about sexual difficulties, past or present.
- Only if the client complained of sexual issues
- However, expectations of immediate response or "truthful" answers at first may not be realistic. In other words, the benefits of seeking this information in an effort to better understand and help the client may take some time- to get the completely true picture.
- Only if the presenting problem indicated some kind of difficulty in this area or in the case of couples where sexual issues might arise
- See above
- No, I wouldn't ask these questions without rapport first
- Patients may not be completely honest; they exaggerate, deny or undermine certain problems. Especially if they are not comfortable with the questions. Can the assessment target the presenting problem of the client? Once the client states the primary purpose of the visit?

- Yes, but only if I had a background in Sexology otherwise, I would not feel comfortable counseling someone with these problems and I myself have no background or experience in this but still it would be helpful
- See #4 for details
- I generally ask about sexual abuse, unwanted touching, etc., but do not generally ask questions that are more detailed. If a patient presented with those complaints, I would likely refer them out. If the issues came up in treatment, I would think that the questionnaire would be helpful in focusing my assessment.
- I believe the SDSQ would be a helpful tool in assessing adult clients in the community
- It would be helpful as it is not threatening, not overtly pressing for information.

For question four of the Practitioner Evaluation Survey, "With whom would you use the Sexual Disorder Screening Questionnaire?" eighteen of the twenty-seven respondents provided explanations to their response for this question. Eleven respondents who said they would administer the questionnaire to some of their clients, provided comments as follows: "This would be a good tool upon assessment if you had other tools to include with it like the MMPI or an intelligence test or the Beck inventory. I would never just give this alone unless the client stated they have sexual issues and I was a certified sex therapist;" Three other responses include: "It gives a fairly good overview-baseline to go forward with"; "Sexual history is a very important part of one's assessment-it can also be very helpful to understand all parts of one's clinical issues-not just the usual questions about mental health" and "This assessment is great to use". Other comments about whether clinicians would use the Sexual Disorder Screening Questionnaire include "after a pre-screening"; "Depending on time, client interests, needs, presenting issues, etc."; "I would say most- but it would depend on the presenting problem. If the client was there

for individual or couples counseling, I would see as a definite tool."; "If they discussed sexual issues."; "I'll have to hear from the client how could be of help, instead of going directly to the questionnaire. Depending on the answer, I would use it or not."; "only those that presented with issues of a sexual nature or couples counseling" and "Some, presenting with sexual problems". Other comments from respondents include, "I would use the SDSQ on adult client who were not incarcerated or in the SOTP; "I'm not sure that all adults would feel comfortable answering these questions as part of the initial process, but, maybe, after developing rapport. I think that all couples coming in for sex therapy and maybe couples counseling would benefit from answering these questions initially."; "Some adults, especially those who seek counseling for sexual issues" and "with some adult clients that might have indicated need". The comment for the respondent indicating they would provide this questionnaire to some of their child and adolescent clients are,"I also work with children and adolescents, and could use some of the questions to ascertain abuse with them". ". The unedited responses are as follows:

- After a pre-screening
- Depending on the efficacy of the questionnaire, it would make sense to use with all adults…novel idea!
- Some adults, especially those who seek counseling for sexual issues
- All adult clients
- Some, presenting with sexual problems
- Sexual history is a very important part of one's assessment-it can also be very helpful to understand all parts of one's clinical issues- not just the usual questions about mental health.
- If they discussed sexual issues

- I would say most- but it would depend on the presenting problem. If the client was there for individual or couples counseling, I would see as a definite tool.
- Only those that presented with issues of a sexual nature or couples counseling
- Depending on time, client interests, needs, presenting issues, etc.
- With some adult clients that might have indicated need
- I will have to hear from the client how could be of help, instead of going directly to the questionnaire. Depending on the answer, I would use it or not.
- This would be a good tool upon assessment if you had other tools to include with it like the MMPI or an intelligence test or the Beck inventory. I would never just give this alone unless the client stated they have sexual issues and I was a certified sex therapist.
- I am not sure that all adults would feel comfortable answering these questions as part of the initial process, but, maybe, after developing rapport. I think that all couples coming in for sex therapy and maybe couples counseling would benefit from answering these questions initially.
- I also work with children and adolescents, and could use some of the questions to ascertain abuse with them
- This assessment is great to use
- I would use the SDSQ on adult client who were not incarcerated or in the SOTP
- It gives a fairly good overview-baseline to go forward with

For question five of the Practitioner Evaluation Survey, "What you found most helpful about the Sexual Disorder Screening Questionnaire" twenty-one of the twenty-seven respondents provided explanations to their response for this question seven respondents reported the questionnaire was easy to use. Three respondents stated the questionnaire would open the client

up to discuss sexual issues. Three respondents reported the broad range of topics covered were the best part of the questionnaire. Other responses to question five included “Structured, impartial and non-suggestive”; “Specific questions for males and females”; “Questions were very pointed and specific. Doesn't "beat around the bush" so you are going to evoke clear responses.”; “Nothing in particular”; “I don't know of any other”; “Everything”; “Difficult question to answer” and “All”. ”. The unedited responses are as follows:

- It covered a lot of ground
- Difficult question to answer
- Nothing in particular
- Very straight forward and easily understood
- It is simple to use
- It covered some sensitive areas not usually addressed
- Specific questions for males and females
- Questions were very pointed and specific. Does not "beat around the bush" so you are going to evoke clear responses.
- I think the questionnaire is helpful in that it enables the client to identify symptoms that might point to concern about sexual matters without being unnecessarily intrusive or making the client feel embarrassed. It provides an initial basis for the client to discuss what might be a difficult and sensitive issue.
- Range of topics
- I don't know of any other
- Structured, impartial and non-suggestive

- It opens the client up and can make them feel at ease about talking about serious or hard to talk about issues but at the same time you would have to be careful the context it was used in. I think this part of a person's life is left out of the therapeutic process all too often and this questionnaire is a good way to take an inventory of where the client is or how they feel about their sexuality.
- It covers most of the sexual dysfunctions and other disorders in an easy manner, but not in depth.
- I thought that it was simple and would not take long to answer, yet would give important information that may not be gained otherwise.
- Everything
- It was easy to complete and concise
- The most helpful aspect was the fact that the questions were listed in an easy to ask manner and that they would help me assess the client more carefully if an issue related to sex and sexuality came up in treatment.
- The straightforward nature and being easy to use was what was most helpful about the SDSQ
- All
- It is simple to use- matter of fact and measurable

For question six of the Practitioner Evaluation Survey, "What changes would you recommend for the Sexual Disorder Screening Questionnaire?" twenty-three of the twenty-seven respondents provided explanations to their response for this question. Eight respondents recommended no changes to the questionnaire. Two of the comments attached to these eight responses are "None. Because the last item provides an opportunity for prospective clients to

elicit areas of concerns that the questionnaire itself offers." and "for a screening it's ok. I would create other more specific questionnaires for any identified problem (e.g. 1 for erectile dysfunction, another one for low sexual desire, etc. but if the objective is to have a screening, this is OK.". Seven respondents suggested adding content to the questionnaire. The suggestions for added content include, "perhaps more questions about their feelings"; "longer"; "it is a bit too brief"; "I would grow with use, as ideas, questions arise, one can just add on more questions."; "I would like to see included in the beginning of the assessment the primary complaint of the client. I would like to hear how he describes his own problem in his own words and understanding. What are the problems perceived by him before anything else."; "I might recommend an expanded area on paraphilias or an additional section for those who may need additional exploration relative to their paraphilic interests."; "ask about sleep/dream related orgasms and emissions… i.e. do you ever experience them, how often, reaction". Four other responses to suggested changes to the questionnaire were as follows: "It is difficult to answer this question without doing research related to these issues."; "I would change the name of it if possible because some clients might feel like they are different or unusual since the name of it is sexual disorder which infers they have a problem.:' "I have a number of suggestions." and "Determine its purpose/target group. "Is it generic or specific?" Additionally, two respondents asked for clarification of certain terms, "Unable to answer just reading it for the first time. There were a few words that may need defining for clients depending on their level of sophistication." and "Perhaps more explanation of the swelling response and involuntary spasms in 9a and 9b." Two recommendations to modify the questionnaire structure include. "I would segregate male and female questions to be all in one question" and "You might want to reconsider the order of questioning. All are great questions but the first one is a little "in your face" right off the bat-

especially when the answer is "yes". Perhaps "warming up" with a little less invasive question would be more comfortable for the client. The question certainly needs to be asked but maybe further down the line of questioning". The unedited responses are as follows:

- I have a number of suggestions
- Unable to answer just reading it for the first time. A few words may need defining for clients depending on their level of sophistication.
- It is difficult to answer this question without doing research related to these issues
- None
- I would segregate male and female questions to be all in one question
- It is a bit too brief
- Longer
- Determine its purpose/target group. Is it generic or specific?
- None
- You might want to reconsider the order of questioning. ALL are great questions but the first one is a little "in your face" right off the bat-especially when the answer is "yes". Perhaps "warming up" with a little less invasive question would be more comfortable for the client. The question certainly needs to be asked but maybe further down the line of questioning.
- None. Because the last item provides an opportunity for prospective clients to elucidate areas of concern that the questionnaire itself offers.
- Ask about sleep/dream related orgasms and emissions… i.e. do you ever experience them, how often, reaction
- Perhaps more questions about their feelings

- I would like to see included in the beginning of the assessment the primary complaint of the client. I would like to hear how he describes his own problem in his own words and understanding. What are the problems perceived by him before anything else?
- I would change the name of it if possible because some clients might feel like they are different or unusual since the name of it is sexual disorder, which infers they have a problem…
- For a screening, it is ok. I would create other more specific questionnaires for any identified problem (e.g. 1 for erectile dysfunction, another one for low sexual desire, etc. However, if the objective is to have a screening, this is OK.
- Perhaps more explanation of the swelling response and involuntary spasms in 9a and 9b.
- Do not know
- None
- None
- I might recommend an expanded area on paraphilias or an additional section for those who may need additional exploration relative to their paraphilic interests.
- None
- I would grow with use, as ideas, questions arise, one can just add on more questions

For question seven of the Practitioner Evaluation Survey, "Would you need additional training in order to be comfortable administering the Sexual Disorder Screening Questionnaire?" fifteen of the twenty-seven respondents provided written responses. Six respondents said yes and provided comments: "Not if those two terms were explained in more detail."; "I would need to know how to interpret the responses I obtained. While I am generally familiar with the different sexual disorders, I am not confident that I would know when follow up questioning is

needed, and I don't feel comfortable treating sexual disorders."; "I have no experience with examining sexual disorders among clients and this is my first time seeing this assessment instrument. I would require quite a bit of training."; "I believe it would be helpful!."; "Further information on certain dysfunctions and also several sources for referrals just in case I am not able to deal with the clients issues and I need some professional advice form a colleague or a referral for my client."; "Because most people are sensitive about sexual matters, it would be good to get ideas on how to introduce the questionnaire and how to explain the purpose and questionnaire to the client to put them at ease and allow them to be as candid as possible in their answers." Seven said they would not need additional training and provided comments: "Questions are easy and straightforward"; "No, but it might cause you to refer to a specialist."; "It's pretty straightforward"; "I would not need additional training before administering the SDSQ"; "I don't know. I think not."; "I am already a sexologist" and "For a clinician, I think it is very user friendly now ". Two respondents said indicated they would not need additional training, providing no comment. The unedited responses are as follows:

- I have no experience with examining sexual disorders among clients and this is my first time seeing this assessment instrument. I would require quite a bit of training.
- No
- It's pretty straightforward
- No
- No, but it might cause you to refer to a specialist
- Questions are easy and straightforward
- I believe it would be helpful!
- Because most people are sensitive about sexual matters, it would be good to get ideas on how to introduce the questionnaire and how to explain the purpose and questionnaire to the client to put them at ease and allow them to be as candid as possible in their answers.

- I am already a sexologist
- I do not know. I think not.
- Further information on certain dysfunctions and several sources for referrals just in case I am not able to deal with the clients issues and I need some professional advice form a colleague or a referral for my client
- Not if those two terms were explained in more detail.
- I would need to know how to interpret the responses I obtained. While I am generally familiar with the different sexual disorders, I am not confident that I would know when follow up questioning is needed, and I do not feel comfortable treating sexual disorders.
- I would not need additional training before administering the SDSQ
- For a clinician, I think it is very user friendly now

For question eight of the Practitioner Evaluation Survey, “Other thoughts or feedback about the Sexual Disorder Screening Questionnaire” fifteen of the twenty-seven respondents provided explanations to their response for this question Six respondents indicated there was nothing to add; four provided accolades; three mentioned language to add to the survey and two provided comments. The suggestions for additional information include: “Perhaps in question 11, the client could be allowed to state how their sexual issues affect their relationships or other areas of their lives.”; “might want to include "please explain" after each question”: and “A statement should be included in the instructions informing the client that it is ok to answer questions that make them feel uncomfortable”. The two comments were: It seems like a relatively non-threatening way to open discussion of sexual issues as part of the therapeutic process.” and “I thought it was helpful and once again should be part of every assessment and every closure session. This way you can see the progress made and what still needs top be addressed”. The unedited responses are as follows:

- None at this time

- A statement should be included in the instructions informing the client that it is ok to answer questions that make them feel uncomfortable.
- Thank you for allowing me to be a part of the survey. Good luck in the future
- Perhaps in question 11, the client could be allowed to state how their sexual issues affect their relationships or other areas of their lives
- It seems like a relatively non-threatening way to open discussion of sexual issues as part of the therapeutic process.
- Might want to include "please explain" after each question
- Great Job!
- I thought it was helpful and once again should be part of every assessment and every closure session. This way you can see the progress made and what still needs to be addressed.
- None at this time
- None
- No
- No other feedback.
- No other thoughts or feedback on the survey at this time...
- Excellent tool
- Good job!

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