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Let's Talk About Sex: The Importance of Sexuality Training in Doctoral Psychology Programs

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LET'S TALK ABOUT SEX: THE IMPORTANCE OF SEXUALITY TRAINING IN DOCTORAL PSYCHOLOGY PROGRAMS

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ABSTRACT

LET'S TALK ABOUT SEX: THE IMPORTANCE OF SEXUALITY TRAINING IN DOCTORAL PSYCHOLOGY PROGRAMS

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Sex is an integral part of human nature and identity (Sanabria & Murray, 2018), yet many clinical psychology programs may not offer adequate sexuality training. This study explored clients' needs for support surrounding sexuality, clinical competence in human sexuality, and the availability of human sexuality training in doctoral psychology programs across the United States. In an effort to create a large sample size, I randomly chose 25 doctoral psychology programs to examine the nature of their sexuality trainings or sex education. Only two of these programs offered classes or trainings, though neither of the programs required the courses for program completion. Due to the qualitative nature of this study and availability of subjects, I chose to interview six locally based individuals who sought therapy from a clinical psychologist within 10 years of this study. Most subjects reported that while sex and sexuality were important factors in their therapeutic endeavors, their therapists lacked awareness or comfort around discussions of sexuality. The findings in this study suggest that the (a) lack of human sexuality training in doctoral psychology curriculums and (b) overall dissatisfaction of the six individuals I interviewed may indicate a need for further studies examining quality and availability of human sexuality training in doctoral psychology programs, and (c) the lack of training offered by doctoral psychology programs may limit clinicians' clinical competency. This dissertation is available in open access at AURA (https://aura.antioch.edu) and OhioLINK ETD Center (https://etd.ohiolink.edu).

Keywords: human sexuality, LGBTQIA, competency, doctoral training

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CHAPTER I: INTRODUCTION

Human sexuality may play an important role in the physical and psychological realms of human nature. Whether due to sexual trauma, sexual identity, relationships, or side effects of mental health conditions or medications to treat those conditions, sex and sexuality could be considered relevant topics in a therapeutic setting. Clients seeking psychological services may discuss traumatic experiences that are explicitly or implicitly related to, or have an impact on, sexuality (McFarlane & Bookless, 2001). They may also bring up sexual issues pertaining to their relationships or their own sexual identity (Hanzlik & Gaubatz, 2012). Additionally, depression and anxiety and their pharmaceutical treatments affect sexual function, and contribute to sexual problems (Baldwin, 2001; Bradford & Meston, 2004; Dording et al., 2012; Johnson et al., 2004). Psychologists with adequate training in human sexuality may more effectively help their clients manage the sexual sequelae of depression and anxiety, sexual trauma, and other concerns regarding sexuality, sexual identity, or sexual function.

The aim of this study was to examine clients' needs for support surrounding sexuality, clinical competence in human sexuality, and existing sexuality training in psychology programs. To do this, I examined a random sample of 25 American Psychological Association (APA) accredited clinical psychology doctoral (PsyD) programs throughout the United States to determine their human sexuality coursework and trainings. I conducted a thorough literature review to review existing studies of how sex and sexuality affect clients in therapy. Lastly, I interviewed clients who sought therapy from a psychologist for sexuality-related issues to evaluate their experience as well as their perception of clinician competence.

The results of this study could indicate the need for more extensive research in order to create a best-practices guide for training clinical psychologists in human sexuality and the

treatment of sexuality-related issues. Further research could help doctoral programs train their students to better meet the needs of future clients on a more holistic level that includes sexuality.

CHAPTER II: LITERATURE REVIEW

Introduction

This literature review examines the relevance of sexuality for clients seeking therapy, existing research on human sexuality in doctoral psychology, and how clinician competency plays a role in effective therapy.

Relevance of Sexuality for Clients

In his literature review, Bancroft (2009) notes that sexual health, while complex to define and unique to different cultures, is connected to an individual's physical, emotional, and social health. In their literature review, Zemishlany and Weizman (2008) found that sexual dysfunction is highly prevalent for people with mental disorders—specifically for clients who take certain medications like selective serotonin reuptake inhibitors (SSRIs). The following sections will highlight the relevance of sexuality for clients seeking therapy.

Posttraumatic Stress Disorder (PTSD) and Sexuality

Childhood sexual abuse has long-term negative effects on psychological health and well-being for both men and women (Briere et al., 1988; Easton, 2014; Godbout et al., 2014; Laumann et al., 1999; Roseler & Mckenzie, 1994; Young, & Widom, 2014). Women report higher rates of sexual abuse, though due to masculine gender norms, men may be underreporting sexual abuse for fear of appearing unmasculine (Basson et al., 2000; Blair et al., 2013). In their literature review, Briere et al. (1988) found that disclosure is a key component of recovery for sexual assault survivors. The authors proposed that masculine gender standards like stoicism, emotional control, and dominance may prevent men from disclosing sexual abuse.

Sexual dysfunction is not a symptom of PTSD, yet PTSD has been shown to negatively affect sexual function (Breyer et al., 2014; Lehrner et al., 2016; Roesler & Mckenzie, 1994).

Multiple studies show that individuals diagnosed with PTSD after serving in the military are more likely to show signs of sexual dysfunction (Bryer, 2014; Hosain et al., 2013; Yehuda et al., 1992). Sexual dysfunction associated with PTSD affects both male and female civilians (Briere & Runtz, 1988; Browning & Laumann, 1997; Cruz et al., 2017; Roesler & Mckenzie, 1994). Lehrner et al. (2016) found that sexual dysfunction in the studied veterans was not due to a medical condition, but rather due to lowered libido resulting from depression which numbs and reduces levels of glucocorticoid.

Depression and Sexuality

Depression ranks within the top five diagnoses in the Diagnostic Statistics Manual 5 (DSM-5; *Common Mental Health Disorders*, 2011). In their systematic review and meta-analysis, Atlantis and Sullivan (2012) found a bidirectional association between sexual dysfunction and depression, meaning the two problems are often connected. Johnson et al. (2004) found that people with depression were 5.3 times more likely to experience lowered sexual desire than those without depression. The use of mood stabilizers, such as SSRIs, has been linked to sexual dysfunction such as decreased libido and delayed orgasm (Montejo et al., 2018; Zemishlany & Weizman, 2008).

Depression affects sexual function in both men and women (Baldwin, 2001; Laumann et al., 1999; Lykins et al., 2006). Men with depression report erectile dysfunction and premature ejaculation, while women experience lowered sexual desire, lowered levels of lubrication, and inability to orgasm (Basson et al., 2000; Basson et al., 2003; Laumann et al., 2005).

Fabre and Smith (2011) found that women with the DSM-IV diagnosis of Major Depressive Disorder (MDD) exhibited a higher rate of sexual dysfunction than those without a diagnosis. With the use of the DeRogatis Inventory of Sexual Function (DISF) and the Hamilton

Depression Rating Scale (HAMD-17), Fabre and Smith (2011) discovered that there was a greater risk of sexual dysfunction for individuals with depression than for those without. The authors suggested medication and psychotherapy that target depression and sexual function may be useful for increased quality of life (Fabre & Smith, 2011; Shindel et al., 2011). Peleg-Sagy and Shahar (2013) suggested that women who are high achieving, such as medical students, may be particularly susceptible to depression and sexual dysfunction. The authors (2013) found that depression may lead to problems with sexual satisfaction, which may then lead to additional depressive symptoms, therefore adding to the cycle of depression.

Medications used to treat depression increase the risk of sexual dysfunction (Dording et al., 2012). This may cause patients to either lower their medication dosage, skip doses, or discontinue medication altogether, which could lead to a relapse in depression (Dording et al., 2012; Gedes et al., 2003; Papakostas et al., 2007). Clinical awareness of these issues could lead to more psychoeducation on potential sexual side effects with clients (Zemishlany & Weizman, 2008).

Considering the potential sexual side effects that depression and medication may have on individuals, psychologists should routinely screen their clients with depression for sexual dysfunction (Baldwin, 2001; Bonierbale & Tignol, 2003; Kennedy et al., 1999; Thase et al., 1988). Conversely, clients who seek treatment for sexual dysfunction should be screened for depression (Araujo et al., 1998; Atlantis, 2012; Goldstein, 2000).

Anxiety and Sexuality

Kaplan et al. (1982) found that individuals with panic disorder feared having a panic attack during sexual intercourse, which contributed to sexual aversion. Figueira et al. (2001) suggested that due to these findings, sexual aversion should be considered as a possible

complication of panic disorder. With the use of semistructured interviews, Figueira et al. (2001) found that social phobia had an even greater influence on sexual function than panic disorder. They suggested that clients who suffer from panic disorders or social phobias in combination with sexual dysfunctions may benefit from a combination of medications and psychological treatment (Figueira et al., 2001; Kaplan et al., 1982).

In their literature review, Pakpahan et al. (2021) found psychogenic erectile dysfunction (ED) to be linked to depression and anxiety. The authors noted that depression alters brain biochemistry and self-esteem, which affect the physiological and emotional ability to have an erection (2021). Anxiety has also been shown to negatively affect female physiological sexual arousal (Aksaray et al., 2001; Bradford & Meston, 2004; Dèttore et al., 2013). In their literature review, Bradford and Meston (2004) found that anxiety disorders negatively impacted women's physiological arousal response. Dunn et al. (1999) noted that female research subjects who self-reported moderate to high levels of anxiety had a significantly higher risk for sexual problems. Neuroticism, a feature of a personality with anxious characteristics, has been moderately correlated with anxiety when engaging in sex and lowered sexual satisfaction (Heaven et al., 2003).

Lesbian, Gay, Bisexual, Transgender, Intersex, Asexual (LGBTQIA), and Sexuality

Individuals who identify as LGBTQIA are part of a culturally diverse population who face specific problems and societal constraints that result in stress on a multitude of levels (Bieschke et al., 2000; Cochran, 2001; Frost et al., 2015). Individuals who identify as LGBTQIA seek therapy to cope with varying experiences, such as external and internalized homophobia, sexual dysfunction, and stigma (Bieschke et al., 2000; Cochran, 2001; Hughes et al., 1997; Matthews, 2005).

Although there has been an increase in awareness and positive attitudes toward the LGBTQIA population (Shelton & Delgado-Romero, 2013), there are still significant gaps in training for psychologists regarding the mental health of these populations (Finkel et al., 2003; Fredriksen-Goldsen, 2013; Fredriksen-Goldsen et al., 2014). Historically, the mental health counseling industry has harmed LGBTQIA individuals, often using therapy as a means to cure homosexuality and pathologize any sexual orientation other than heterosexual (Glenn & Russell, 1986). Though the DSM removed "homosexuality" as a mental disorder in the early 1970s, Glenn and Russell (1986) found in their qualitative study that therapists viewed homosexual clients as more pathological than heterosexual clients. The authors determined that based on their findings, counseling schools should offer training in sexuality to reduce bias (Glenn & Russell, 1986).

Without proper training, I believe psychologists may inadvertently cause harm to their clients through microaggressions. Shelton and Delgado-Romero (2013) define microaggressions as "communications of prejudice and discrimination expressed through seemingly meaningless and unharmful tactic" (p. 210). These microaggressions are subtle and could have a negative influence on the therapeutic relationship.

Being homosexual or transgender is widely stigmatized in American society (Cochran, 2001; Herek et al., 1991). Because of this, lesbian, gay, and transgender clients may experience multiple stressors on a variety of levels due to the societal stigma of their sexual minority status, affecting both the individual and their relationships (Otis et al., 2006). Minority stress includes stigma, prejudice, and discrimination that may impact individuals' physical and mental well-being (Cochran, 2001; Frost et al., 2015; Herek et al., 2007; Myers, 2003).

Sexual Dysfunction

There are a variety of predisposing factors for sexual dysfunction, including family of origin; religious beliefs; sexual, emotional, or violent trauma history; and medical reasons (McCabe et al., 2010). Partner humiliation, poor communication, or discovering a partner's infidelity may cause loss of confidence, loss of sexual desire, or erectile dysfunction (McCabe et al., 2010). Sexual dysfunction affects the physical, social, and emotional aspects of quality of life (Basson et al., 2000).

McCabe et al. (2010) assert that by taking a biopsychosocial approach to treatment for sexual dysfunction, therapists are able to assess for predisposing, precipitating, and maintaining factors. Examining relational issues, life stressors, medical concerns, and current treatments (including medications that may be affecting the client's sexual function) are important in helping the client attain healthy sexual function and sexual pleasure (DSM-5, 2013; Ferguson, 2001; Levine, 2017).

Existing Sexuality Training for Psychologists

While sex and sexuality are integral components of the human experience, Reissing and Giulio (2010) found that in a survey of 188 clinical psychologists, 60% did not inquire into their clients' sexual health. Wiederman and Sansone (1999) conducted a survey of APA approved doctoral programs and discovered that only one in five offered training on sexual dysfunction, HIV/AIDS, and working with the LGBTQIA population. The lack of available training may impact a psychologist's confidence when discussing sex with their clients (Regas, 2011).

Byers (2011) studied 115 graduate students from 17 accredited graduate psychology programs, where 24–75% of the students reported that their programs addressed none of the nine

topics regarding sexuality (such as sexual trauma, orientation, and dysfunction). Those same students reported spending significant time working with clients on sexual issues (Byers, 2011).

Reissing and Di Glulio (2010) conducted a study that showed clinical psychologists were not receiving adequate training in how to assess, refer, and treat issues of sexual health. These authors also found that over half of the 201 participants in their study reported discomfort discussing sex due to the lack of training (Reissing & Di Glulio, 2010). In the same study, 60% of the clinicians reported asking their clients about sex sometimes or not at all (Reissing & Di Glulio, 2010). A study by Rona Rubin (2004) found that due to their desire to maintain a masculine image, men were less likely to bring up sexual dysfunction in therapy.

Clinical Competency and Ability to Discuss Sexuality

Clinical competence is a major step towards assisting a clinician in being able to work with clients in issues of sexuality. Competency is defined as "habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served" (Epstein & Hundert, 2002, p. 226). This definition has since been expanded, as seen in the Cube Model, which includes the development of a professional psychologist's competency. This model expands core competency to include 12 core competencies that are either *foundational* or *functional* (Rodolfa et al., 2005). The foundational competencies refer to the core skills a clinician is expected to achieve knowledge, skills, attitudes, and values (KSAV). The functional competencies include research and consultation, the knowledge and understanding of ethics, and how to work within cultural diversity.

Competency and Comfort

Multiple studies indicate that healthy sexual function is correlated with satisfaction and well-being and is part of the human experience throughout the lifespan (Bancroft, 2009; Laumann et al., 2006; Reissing & Di Glulio, 2010). Hanzlik and Gaubatz (2012) found that if clinicians do not broach the topic of sexual health, clients are less likely to bring up sexual issues on their own. Sexuality is a relevant part of the therapeutic discourse, so when a clinician can comfortably discuss sexuality, it conveys the message that it is both welcome and therapeutically appropriate to discuss in therapy (Wiederman & Sansone, 1999).

In their study, Hanzlik and Gaubak (2012) found that when clinicians go through sexuality training, they experience greater comfort in discussing diverse sexual issues. Hanzlik and Gaubatz (2012) directed a study using 138 doctoral students to establish their comfort in discussing sexuality with their clients. The results showed that although clinicians may be comfortable discussing sex on a global level, they are less comfortable when more specific topics about sex are brought up, such as "do you experience morning erections?" (Hanzlik and Gaubatz, 2012).

Competency and Ethics

Kaslow (2004) defined competence as "an individual's capability and demonstrated ability to understand and do certain tasks in an appropriate and effective manner consistent with the expectations for a person qualified by education and training in a particular profession or specialty thereof" (p. 775). She stated that competency involves following ethical guidelines, clinical judgment, and doing what is right for the client. By failing to provide education and training on human sexuality to psychologists, training programs may effectively be limiting a psychologist's competence and awareness as it pertains to all areas of health/well-being of

clients (Cruz et al., 2017). These psychologists may not integrate sexual history-taking into their intakes or interviews with clients; they may also be uncomfortable and unable to effectively respond if and when a client brings up issues associated with sex/sexuality in therapy (Hanzlik & Gaubatz, 2012; Wiederman & Sansone, 1999).

Burnes et al. (2017) asserted that sexual violations are the number one ethical violation within the field of psychology. This lack of training could lead, at best, to clinicians missing out on important factors for assessment, intervention, and monitoring progress and outcomes, and at worst this lapse could leave a client feeling stigmatized and isolated (Burnes et al., 2017). Both issues would violate the APA ethics code, "Standard 2.01 Boundaries of Confidence," in which "psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience" (American Psychological Association, 2017, Competence section, para. 1).

Human sexuality training includes educational and diagnostic factors as well as ethical and personal factors (such as a clinician's comfort in talking about sex or bias around sexuality). Many authors have asserted that clinicians would benefit from discussions of hypothetical situations, as well as discussions regarding trainees' own discomfort and biases around sexual topics during this kind of training (Cruz et al., 2017; Wiederman & Sansone, 1999).

CHAPTER III: METHODS

The purpose of this study was to explore clients' needs for support surrounding sexuality, clinical competence in human sexuality, and the availability of human sexuality training in doctoral psychology programs across the United States. The study included (a) an investigation of current training offered within APA-accredited clinical doctoral programs in the United States, (b) a literature review, and (c) interviews with individuals who have sought psychological services.

In this chapter, I will outline the methodological procedures, literature review, ethical considerations, and data collection methods.

Research Method

I chose an interpretive phenomological analysis (IPA) as the method of study. I used snowball sampling to collect participants and conducted in-depth, semistructured interviews. An IPA is a qualitative approach that I will rationalize and outline in this section.

Qualitative Methods

Qualitative methods allow researchers to focus on context, experiences, and stories to analyze information (Bogdan & Biklen, 2007). These methods generate research questions based on themes that emerge as data are collected, rather than forming numerical data as in quantitative research analysis (Creswell & Creswell, 2017). In the absence of appropriate statistical applications, researchers analyze qualitative data using the theory that informs the method (Creswell & Creswell, 2017). I chose a qualitative methodology for this study as it allowed me to interview clients and examine the scope of their experience discussing their sexuality with a clinician. I conducted a document analysis of programs that offer human sexuality courses to examine gaps in existing trainings or areas that may need improvement. It is my hope that this

research can inform future clinical psychology programs on best practices for human sexuality training.

Interpretive Phenomenological Analysis

Smith (1996) describes IPA as having three components: phenomenology, hermeneutics, and ideography. IPA uses a bottom-up approach, meaning the research is not done with the intention of testing a hypothesis, but instead grounded in collecting and interpreting the experiences of individuals with the assumption that they are the experts of their lived experiences (Reid et al., 2005). Pietkiewicz and Smith (2014) explain that IPA focuses on the participant's meaning-making of their experiences. This method assumes the participants are actively engaged in interpreting their relationships and lives. Using double hermeneutics (the notion that both the interviewer and interviewee engage in co-meaning-making throughout the interview process), themes that emerge from interviews are paired with the interviewer's own interpretations (Pietkiewicz & Smith, 2014). The researcher then reflects on their thoughts and previously held beliefs, observing how those may have impacted the interview process, interpretation of results, and write up of data (Reid et al., 2005; Smith, 2017).

This is an appropriate method for this study as it collects narratives from the client's experience and information about my own bias or lack of training in human sexuality. This adds an additional layer to the themes that may emerge during this study.

Literature Review

I conducted a thorough literature review to determine existing human sexuality training in psychology programs, relevancy of sexuality as it pertains to mental health, and how clinician competency impacts the client experience. I then compared this information with the current training in APA accredited clinical psychology programs to evaluate gaps in current training

models. The literature review and evaluation of current training programs helped identify training gaps and best practices in human sexuality training for psychologists.

Ethical Considerations

I followed the ethical guidelines as outlined by the APA and used specific methods to protect confidentiality. Alase (2016) states

> that as a qualitative research study, it is imperative and ethically important that an IPA study is cognizant of the rights and privacy of the individuals participating in the project. It is anticipated that participation in any IPA study will be strictly voluntarily based and the risks to the participants should be very minimal. It is, however, important that no harm should come to the participants in an IPA study. IPA research study should provide adequate measures of protection for the rights and dignities of its participants, because participants in an IPA study should be better off knowing they were able to tell the stories of their "lived experiences;" not worse off from it. (p. 92)

I submitted an application to the Institutional Review Board (IRB), a required measure to ensure the safety of participants. This submission passed inspection. I informed each participant of the interview process, noting any benefit or harm that may come from the study and that they were there on their own volition. I informed participants that they could choose to not answer any question for any reason, take breaks as needed, and end the session at any time and discontinue their participation in the study. Participants completed informed consent verbally regarding the recording and use of data. I kept all recordings from interviews on an encrypted device. During the transcription process, I assigned each participant a number and removed all identifying information from the data.

Data Collection and Analysis

Each subject completed a face-to-face, semi-structured interview in a one-to-one situation. I recorded each interview and transcribed them verbatim. I took descriptive notes (Creswell, 2003) during the interview in order to reflect upon personal thoughts and ideas to use for the analysis process.

Sampling

I used convenience and snowball sampling to identify participants. Using word of mouth, I sought out participants from the Bachelor's degree programs at Antioch University in Seattle, Washington. The study called for a minimum of six participants to attain research saturation. Inclusion requirements were (a) participant had been in therapy with a licensed clinical psychologist (PsyD) in the past five years and (b) participant discussed sex, sexuality, or wanted to discuss sex and sexuality but did not do so (Appendix A). I required participants be over the age of 18.

I created flyers for participant recruitment, which included an email address created specifically for the study. Once a participant emailed me, I contacted them by phone to discuss inclusion criteria. I planned for each interview to take no longer than an hour and notified participants in advance of the expected time. I determined quiet and discrete locations for each participant.

I did not offer or give participants financial incentive to participate in this study. I explained that by agreeing to take part in this study, participants may help create a better understanding of what is needed to train psychologists so that they may better serve their clients.

Data Analysis

As indicated in an IPA, I analyzed data for themes and overall meaning with emphasis on viewing interviews holistically. Because participants' eloquence of a particular story point may influence the overall narrative of the interview (Smith et al., 1999), I aimed to focus on the overall content of each interview.

The first stage of analysis included reading the transcripts twice through. I made notes in the margins to begin the meaning-making process. The next stage included reading the transcript

again, this time using the other margin to begin pulling out themes (Smith, 2015). For this type of data, researchers may begin pulling broad themes and then breaking them down into more concise themes, paying close attention to each individual's experience of events (Senior et al., 2002). After pulling out themes, I clustered themes by participant, which resulted in a master table of themes for all participants in the group (Smith, 2015).

Brocki and Wearden (2006) note that it is important to screen for researcher bias while reading transcripts and make notes of any that may arise. The phenomenological aspect of data analysis involves the researcher taking quotes from each participant and using them verbatim (Smith, 2015). I used coding to use track my own interpretation of the data, taking into careful consideration the experiences of each participant. I journaled thoughts and questions during the entire process. I analyzed all research results to thoroughly and conscientiously self-reflect and present results that were meaningful and respectful of each participant's experience (Alase, 2017).

CHAPTER IV: RESULTS

Introduction

This study involved three components: a survey of programs, a review of literature, and interviews of clients whose therapists were trained in PsyD programs. I analyzed the gaps in current training in human sexuality at APA-accredited doctoral psychology programs as well as the needs of clients.

With the use of a random number generator, I first did a random survey of 25 PsyD training programs throughout the United States. Of the 25 sampled PsyD programs, only two offered training specific to human sexuality. These two courses were electives, and not required for program completion. It is unknown how many other courses may have included a segment or discussion focused on sex or sexuality.

Second, I conducted a thorough literature review to better understand the needs of clients. Existing literature revealed that many mental health conditions, including PTSD, anxiety, and depression can either cause sexual dysfunction or develop as a result of issues rooted in sex and sexuality. Mental health conditions may develop due to medication side effects or fear of anxiety attacks during sex (Kaplan et al., 1982). The literature review also showed that people who identify as LGBTQIA face specific issues related to sex and sexuality.

Finally, I interviewed six clients who engaged in therapy with doctoral trained psychologists to obtain their experience of their clinicians when discussing sex and sexuality. I screened these individuals to ensure they met the basic requirements of: (a) being over the age of 18, (b) having seen a PsyD licensed psychologist within the past five years, and (c) discussing sex or sexuality in therapy or wanting to discuss sex and sexuality but not doing so.

As illustrated by the idiographic narratives included in this chapter, participants reported having diverse identities. Although their reasons for seeking therapy varied, each participant expressed the importance of their therapist being comfortable and knowledgeable when discussing sex in its many forms.

The results from these interviews are listed below.

Table 1

Primary, Secondary, and Tertiary Themes

Primary Theme	Secondary Theme	Tertiary Theme
Experiences of Support	Satisfying Experiences Unsatisfying Experiences Communication	
Relationship with Clinician	Parental Figure Connection Boundaries	Respect Safety
Discussion of Sex/Sexuality	Perceived Judgement Ability to Discuss Sex	Failure to Ask Hard Questions Failure to Discuss Sex

After multiple readings and careful analysis of the transcripts, I discovered three primary themes and eight secondary themes. The primary themes were Experiences of Support, Relationship with Clinician, and Discussion of Sex/Sexuality. All themes are organized in Table 1, and each theme and their subthemes will be discussed below.

Experiences of Support

Table 2

Primary, Secondary, and Tertiary Themes for Experiences of Support

Primary Theme	Secondary Theme	Tertiary Theme
Experiences of Support	Satisfying Experiences	
	Unsatisfying Experiences	

Participants offered narratives of their personal experiences working in therapy with psychologists. Within the primary theme of Experiences of Support, subthemes of Satisfying Experiences and Unsatisfying Experiences emerged for each participant. I chose to use specific excerpts taken from these narratives to allow participants to use their own voice in painting a clear picture for the reader. To protect identity, I have changed participants' names to pseudonyms and removed any other identifying information.

Satisfying Experience

Participants shared many positive experiences in therapy. The amount of time explicitly focused on sex or sexuality varied. Sex was often a topic that did not play a major role in why participants sought therapy, but many participants shared experiences of bringing the topic up at some point during their therapeutic relationship. Out of the six participants in this study, only two shared that they had an overall favorable experience with their psychologist. The other four shared either having a negative or mixed experience.

Sue. Sue identifies as a cis gender, autistic, White woman in her early forties who sought therapy for "procrastination" and "relationship issues" (personal communication, May 14, 2020). She shared that she identifies as having a "fluidity of sexual identity," and has more recently been "questioning," although she has a history that is "mostly heterosexual" (personal communication, May 14, 2020). Sue shared that although sex was not her primary reason for

seeking therapy, the topic of sex came up multiple times during her therapeutic relationship. Sue described her experience regarding conversations about sex and sexuality in therapy as mixed. On one hand, she felt her therapist supported her, yet there were times when Sue felt her therapist took a more judgmental approach (personal communication, May 14, 2020). Sue shared, "it's like there's nothing with her that's just bad or nothing that's just good, it's all so human" (personal communication, May 14, 2020). Sue expressed that while she felt well supported by her therapist, there were times when she felt judged by her, "When she uses a psychodynamic perspective, it feels a lot more like I can be free to say things without judgement and talk through them more with her" (personal communication, May 14, 2020). Overall, in response to how Sue felt about her therapeutic relationship she shared, "I see it as a gift ... she is a really extraordinary person and she always treats me, when she's being intentional, she always treats me that way" (personal communication, May 14, 2020).

Jason. Jason identifies as a White, cis gender, "mostly" heterosexual male, noting, "I am heterosexual to a point" (personal communication, November 22, 2020). He shared he has a history of seeking therapy for a variety of reasons since adolescence, with his most recent therapy experience being a positive one. Jason reported seeking therapy most recently for help with his relationships and to help him work on codependency. He shared that he has a history of sex "defining my relationships, something I wanted to explore and move away from" (personal communication, November 22, 2020). Jason described therapy as a helpful tool for increasing his self-awareness and bringing a more positive outlook to his view of both himself and his relationships:

> I think my therapist did a really good job. I'm a lot more aware of everything going on around me now and I'm a lot more aware of the positive things, instead of … if I'm going to be hurting someone, I'm more interested in how I'm going to be a positive aspect of their life. (personal communication, November 22, 2020)

Sonia. Sonia shared that she identifies as a cis gender, heterosexual, White woman. She reported that she first sought therapy 11 years prior to this study to explore her history of trauma, including sexual trauma, PTSD, and intimacy and relational issues in her marriage. She described her therapist as her cheerleader and someone who has helped her work through strong feelings of anger and sadness. Sonia shared that therapy provided a safe place for her to process and share the intimate details of her life. "I think therapy has always provided me with a sense of safety and a safe place to share my most intimate thoughts and the things that really bother me, that other places can't provide" (personal communication, April 3, 2020).

In reflection of her time in therapy, Sonia shared an overall good experience that was above and beyond her expectations. She described having a close relationship with her therapist and feeling strongly supported by her—enough to focus on projects she did not feel she would have otherwise completed:

> Actually, I think my goals and needs have exceeded what I thought they could. I think seeing her has allowed me to finish my bachelor's degree and then seek the doctoral degree that I'm seeking. If I hadn't been sitting on her couch, I'm not sure I would have gone through with those two. (Sonia, personal communication, April 3, 2020)

Unsatisfying Experiences

Some participants shared experiences they found unsatisfying while in therapy. Several participants reported seeking therapy for a relationships or intimacy-related issues, but not receiving actual care surrounding these issues. Other participants reported trying to work through sexual trauma or sex-related issues and feeling disappointed by their therapist's invalidation or focusing on tools over empathy.

Sonia. Although Sonia described her therapist as helpful and supportive, she also noted there were times when she would have liked more from her. She shared that there were moments

when she felt lonely in the room during therapy. Although these times were rare, they stood out to Sonia:

> I feel like she's a cheerleader, she's on my side. But I will say I think, there's times … and I'm thinking that at this point, I would just, at times, like her to join me in my pain. Like, she does sometimes, but sometimes I just wish she'd kind of really join me and she has a tendency to be more stand-off. Like she just lets me sit in it. (personal communication, April 3, 2020)

Sue. Sue shared that early in their therapeutic relationship, her therapist had little knowledge when addressing autism and/or sex. Sue noted that one of the reasons she was seeking therapy was for a difficult relationship, which involved her wanting to talk about some of their power dynamics, including sexual ones. "One of the first times I brought it up [sex], I felt judged by her" (personal communication, May 14, 2020). Sue noted that this felt like a barrier in getting her needs met when she wanted to discuss anything sexual in nature (personal communication, May 14, 2020).

Amy. Amy shared that she identifies as Chinese and White and that she is questioning identifying as gender neutral. She stated she "presents as female," uses she/her pronouns, but is currently exploring other alternatives (personal communication, February 26, 2020). Amy shared that she was also "questioning my sexuality, I have a history of only heterosexual relationships, but I also identify as bisexual" (personal communication, February 26, 2020). Amy reported seeking therapy for her history of lifelong trauma (sexual and other) and ADHD. Despite stating her therapist was helpful in many ways, Amy said that at times she wished for a more action-oriented approach:

> I don't know if we went far enough ... because I still experience … and I think I've learned that retrospectively … is that, I just still experience somatic things related to the sexual trauma and because I haven't addressed that, I don't think those things have been resolved, specifically. (personal communication, February 26, 2020)

Janet. Janet identifies as a White, Jewish, cis-gender, heterosexual female in her forties. She stated she sought therapy for multiple issues: "It was the end of my marriage. I had issues with intimacy and codependency. I was just unhappy and feeling lost" (Janet, personal communication, May 13, 2020).

Without knowing how to ask her therapist for more, Janet shared that she wished her therapist had taken a deeper look into her issues, instead of "just focusing on giving me tools" (personal communication, May 13, 2020). She stated that she would have appreciated her therapist broaching her issues with codependency as well as looking deeper into relational issues (personal communication, May 13, 2020).

Brandy. Brandy is in her thirties and identifies as White, queer, and genderqueer. Brandy had the least satisfactory experience with her therapist out of all the participants. She shared that she often felt like her therapist was invalidating, especially surrounding her reported trauma. She noted that at times she did not feel seen by her therapist or that he was dismissive of her experiences. Brandy described bringing up her history of sexual trauma with her therapist:

> Either I'm a hormonal teenager, just like, writing it off, or fact checking. Now that I look back, I think it was … they kept responding with ways to make me … they were trying to give me tools to cope with anxiety instead of actually looking at what my anxiety was stemming from. They were like, 'Oh well, that's fine.' Or 'Let's fact check this; you're probably just being irrational.' Or, 'It's ok.' They were trying to use a lot of rational, reasoning, logical, instead of actually looking at everything else...and no one even asked any of my history, which I'm also surprised by, looking back. (personal communication, March 9, 2020)

In response to her experience with her therapist overall, and her need to address her history of sexual trauma, Brandy stated:

> Looking back, I really wish … there were so many red flags that I hadn't even mentioned, that they didn't even follow up on. And I'm not sure if it was that they were shy, or that they just didn't realize that those were red flags. Does that make sense? And I really … like all I really wish is that someone would have seen those red flags and said, 'Hey, let's explore that.' Because no one ever did. They just glossed over it. Yeah. So, I

> felt … honestly, I look back now and I feel failed. (personal communication, March 9, 2020)

Relationship with Clinician

There are three secondary themes in the primary theme of Relationship with Clinician and two tertiary themes. The first secondary theme, Communication, refers to the participants' experience of the quality in communication between them and their clinician. The second, Parental Figure, connects the participant's view of their therapist as it relates to a parent or guardian. Connection refers to feelings of connectedness, or lack thereof, with their therapist. Lastly, Boundaries refers to the limits and confines therapists created to give their clients a feeling of safety and support.

Table 3

Primary, Secondary, and Tertiary Themes for Relationship with Clinician

Primary Theme	Secondary Theme	Tertiary Theme
Relationship with Clinician	Communication	Respect
	Parental Figure	Safety
	Connection	
	Boundaries	

Communication

Communication plays an important role in a successful therapeutic relationship. Some participants shared that their communication with their therapists felt solid, while others described breakdowns in communication that lead to ruptures in the therapeutic relationship.

Jason. Jason shared that he felt communication was good overall, although it took some time to establish. He described therapy as a place he was able to work on his own ability to communicate and helped him learn how to communicate better within other relationships in his life. Jason shared that he would reflect on the discussions between him and his therapist, and

> consider how my own ability to communicate affected our relationship. It took a minute, you know. You gotta kind of give it up though, because it's establishing … we're in a time and age where you're establishing a new dialogue and opening new pathways and establishing relationships in short periods of time, and you know, really trying to identify if there's a problem, how that problem fits and if there is a treatment or if there's just dialogue that needs to be had. So, in that regard it took us some time to find the language to communicate with each other. (personal communication, November 22, 2020)

Sue. Sue stated that at times she did not feel understood by her therapist and that these times placed a strain on the therapeutic relationship:

> I feel like last week there was something that happened where I really didn't feel respected and it was because I said something difficult that I was experiencing emotionally, and then she tried to explain to me how she felt, and that must be how I feel too. And I was like, 'What?' I thought to myself, 'Maybe she's really uncomfortable with my feelings and doesn't know how to respond and that's why she's telling me how she feels.' It wasn't like she was telling me how she feels about what I said, she was telling me how she feels when I feel … or when she has the similar kind of feeling. There's a lot of places in our relationship where we completely don't connect, or where I experience something that is kind of painful or not as respectful as I'd like to feel. (personal communication, May 14, 2020)

Amy. "For the most part," Amy said, she felt there was solid communication between her and her therapist (personal communication, February 26, 2020). Amy shared that her therapist "always spoke to me in a very respectful manner … did not use any aggressive communication … was very open ended and didn't have a specific reaction to the things that I said" (personal communication, February 26, 2020). She stated there were times when they may not have explored as much as she might have liked, but that she felt this might also be "because of my own apprehension with being forthcoming all the time about certain things that I was just being precontemplative about" (personal communication, February 26, 2020).

Parental Figure

Some participants shared that they viewed their therapist as a parental figure. At times, participants found this beneficial in their healing process. Sue shared that her connections with her therapist felt similar to her relationship with her mother.

> I think in a lot of ways, she's more important than my mom. I have told her that. She's kind of a surrogate mom to me. It's also one of the things I really love about my relationship with her, is that she … even though she acts like a mom to me a lot of the time, she treats me like an adult.

> She's near my parents age, so I wasn't expecting that we were going to have really open and honest conversations, especially sex, from the beginning [of the therapeutic relationship] and certainly somebody who can't help me. (personal communication, May 14, 2020)

For some participants, viewing their therapist as a parental figure made it difficult to broach sexuality as a whole. Amy stated,

> My own discomfort with kind of bringing it [sex] up or going into detail with a male, who I saw as more of a father figure … I felt safe with my therapist … with him and his personality style … with all of that. I think it's just the dynamic of him presenting like a father figure to me that impeded with my comfortability. (Amy, personal communication, February 26, 2020)

Connection

All participants described having some level of connection with their therapist during the therapeutic relationship. Even those participants who went on to share therapeutic ruptures or feelings of being misunderstood by their therapist indicated there were times they felt a connection.

Sue noted, "She actually knows me better than most people and she knows maybe what I need more than I do sometimes . . . with her limitations and what she doesn't know, it feels just

fine because she acknowledges what I know and how I learned it and what it means to me" (personal communication, May 14, 2020).

Amy and Brandy shared similar experiences:

> I think there's a lot of reparative kind of aspects about my father issues, I guess in a sense. In a way I felt that he provided a safe, mentoring kind of relationship where I felt like he was proud of me in a sense, but in a way that wasn't crossing boundaries. It was like, I'm meeting his expectations therapeutically. It became reparative in that relational process. (Amy, personal communication, February 26, 2020)

> It was someone who listened to me. It was a man in my life, who listened to me and at least validated me. A man who, when I did talk about sex with him, it was the first man I've ever talked about sex with in a way that like … it wasn't gross and it was a very neutral stance. And I almost needed that, because I had always seen sex as toxic, really poisonous stuff back then. And so, the validation and almost normalization of just how people talk and how people can talk about things. And despite … even though there was lack of boundary setting and establishing and it was very clear, "He knows more than me and here I am just a teenager." I still … that validation and I guess, comfort, of being around someone that I wasn't afraid of … I didn't feel like he was going to try and rape me or anything…there was something kind of nice about having that person in my life that I have never even been able to talk with. And I think the fact that it was a man, played a big role in that, probably. (Brandy, personal communication, March 9, 2020)

Boundaries

Participants reported varied stories about how their therapists set boundaries. Some participants felt their therapists set clear and structured boundaries, while others felt the boundaries were inconsistent or nonexistent. Each participant shared a different experience with boundaries, some felt their therapist set clear, structured boundaries, whereas others reported boundaries were inconsistent or nonexistent.

Jason. Jason shared that he felt safe withing the boundaries established by his clinician, that he felt he could be "an open book" (personal communication, November 22, 2020).

Sue. Sue reported her therapist was inconsistent in setting boundaries and that it seemed to depend on the issues discussed in each session. She indicated this confused her: "Her

boundaries are really clear around some things and then not clear at all around things she doesn't know (personal communication, May 14, 2020).

Sue shared that her therapist held flexible boundaries, but not always in a way that felt reparative. She discussed that at times her therapist held strong boundaries, but these times were not necessarily helpful:

> I mean there's just such an awkward "let me shove the Kleenex box near you or let me point to where it is" that happens when I'm crying or flooding, and that's where I've felt the boundaries the most, is where I'm having emotions and the person that I'm sitting there with is really limited in her responses . . . I think the issues, including sex and sexuality … they can't be treated that way. (personal communication, May 14, 2020).

Brandy and Amy. Brandy indicated her therapist's lack of boundaries contributed to her negative experience, while Amy noted a positive experience with her therapist's ability to set boundaries.

> Boundaries were never even established. Part of that … part of me feels like my psychologist that I had seen … that maybe other people he treated with boundaries and laid things out and groundwork and everything, but there was never anything like that with him. He is the one person … and again, him and another person more recently, that I've ever talked about sex with. And so, him as the first experience of talking with anyone … yeah, there was zero anything laid out of like, "Hey, I think we should maybe go through these lists of questions. Can I ask you if you feel comfortable, yes/no, or whatever … everything stays in this room" and boundaries like that … yeah nothing, I was given nothing. (Brandy, personal communication, March 9, 2020)

> There were always boundaries and he always spoke to me in a very respectful manner … did not use any aggressive communication … was very open ended and didn't have a specific reaction to the things that I said. (Amy, personal communication, February 26, 2020)

Respect

Participants talked about their feelings of respect toward their therapist, as well as how they did or did not feel respect from their therapist. Jason reported feeling a mutual respect

between him and his clinician and acknowledged that he first had the "white coat syndrome" (personal communication, November 22, 2020). Each participant shared varied levels of respect in the therapeutic relationship.

> There's a lot of places in our relationship where we completely don't connect, or where I experience something that is kind of painful or not as respectful as I'd like to feel. But I feel like that tension and my desire to address it and go back and say 'I didn't feel respected' And I will . . . it usually takes me two or three weeks, but I do and that's different that I used to. (Sue, personal communication, May 14, 2020)

> I respect her tremendously. How I see her respecting myself as a client is that she and I are in a relationship together. She allows me to drive the bus, but sometimes I actually think she is driving. (Sonia, personal communication, April 3, 2020)

> I definitely respected him because I was intimidated and they're professional and they're the expert. I don't know … neutral. (Amy, personal communication, February 26, 2020)

Safety

Some participants discussed if and how they felt safe with their therapist. Jason felt safe, explaining he felt his long history of seeing therapists, beginning in his childhood, led to the feeling of safety with his current clinician. Sonia shared a similar narrative, a long history of seeing therapists, as well as an 11-year relationship with her current therapist, led her to feel safe. Other themes of safety were mixed: the majority of participants reported feeling both safe and unsafe with their clinician.

> I felt safe with my therapist … with him and his personality style … with all of that. I think it's just the dynamic of him presenting like a father figure to me that impeded with my comfortability. When it comes to comfortability, on a scale of one to ten, I would rate it like a three to four. So, it's not even that uncomfortable for me to talk about it, but it just never happened, you know. But otherwise I felt safe with him. (Amy, personal communication, February 26, 2020)

> The only safety I felt was knowing that I have HIPAA laws to protect me … that my information isn't going to be disclosed. I never really … the only safety I felt was logically knowing, well yeah, no one's going to read what I tell this guy in this room. (Brandy, personal communication, March 9, 2020)

> Yeah, they were comfortable, kind of, in certain ways. Their attempt to validate me, I appreciated. They were trying to be comfortable but it felt like they were a little aloof. They just saw me as a teenager that was just, you know … some teenager that clearly was probably struggling with disordered eating and anxiety and depression and I just didn't feel seen, at all. (Brandy, personal communication, March 9, 2020)

Discussion of Sex/Sexuality

The subthemes in the following section refer to how some participants felt judged by their therapist when bringing up sex. Ability to Discuss Sex emerged from various stories of how participants felt their therapist navigated discussions of sex.

Table 4

Primary, Secondary, and Tertiary Themes for Clinician Ability to Discuss Sex

Primary Theme	Secondary Theme	Tertiary Theme
Discussion of Sex/Sexuality	Perceived Judgment	Failure to Ask Hard Questions
	Ability to Discuss Sex	Failure to Discuss Sex

Perceived Judgment

Some participants indicated they felt judged by their therapists, whereas others did not feel any judgment. Jason shared having a very open, nonjudgmental therapeutic relationship:

> Oh, absolutely non-judgmental diagnosis, for lack of a better term. I didn't feel like anything I was doing was the equivalent of slut-shaming or … I'm Black-Irish-Roman-Catholic…you can't come from a more judgement position. To be raised that way and then to have any kind of kink or any kind of deviation from hetero-normative life was like, 'How could you?' For a doctor to be like, 'You're fine. You're healthy. You're doing things right. You're not hurting people. You're being an active member of community. This is a step you're taking.' It's like, 'Oh, you can tell me fucking, whatever you want tomorrow, and I will because I thrive on that kind of approval.' For a doctor to take that time to validate anything that I am not being horrible and to be … to feel that way, probably did more levity to my soul and spirituality than anything anyone had ever done. [I felt] none. Open book. The minute you have boundaries of somethings … I think I was sometimes more embarrassed of what I was telling my psychologist than what I would tell anybody, but at the same time, if you don't tell them, they're not going to know. And I never felt judgment on their part. (Jason, personal communication, November 22, 2020)

On the other hand, Sue shared feeling judged early on by her therapist:

> One of the first times I brought it up, I felt judged by her. I had met someone and it wasn't very long into the relationship that we were sexually active, and the faces she was making made me feel that she was judging me about it. (personal communication, May 14, 2020)

Failure to Ask Hard Questions

Participants described times they felt their therapist did not ask enough questions or failed to take dig deeper during sessions. Amy explained her therapist treated her with "kid gloves" at times:

> I feel like, because he didn't push me too much … in fear of damaging the rapport because I'm … because of the way I am … I think he didn't push me too hard or hold me accountable to the things I would say I would do and then not do. I wish that he did … I wish he was more action-oriented. I wish that he would have been more … I'm sure there's a more tactful way that I could have done that without damaging the rapport … that I could have met my goals. I think I just wanted more structure and so that … push . . . would have helped. (personal communication, February 26, 2020)

Janet shared that her therapist was very action-oriented. She said that perhaps this was her therapist's therapeutic style, but in being so action focused, she never took time to dig deeper. Janet shared that although the tools her therapist provided were helpful, they never got any further into the reasons she was seeking therapy (personal communication, May 13, 2020).

When exploring her sexuality, Brandy shared that she felt her therapist did not have enough training to help her:

> I wish he would have had the tools to know how to bring up the conversation in a more fluid way, and I really wish he would have been able to ask me those hard questions, because honestly it would have provided me so much more healing sooner. If I would have been able to reflect on the things that I was feeling and had experienced. And because I didn't have that opportunity, I never processed it until later. That's a big one. He was trying really hard to get my anxiety and everything managed with meds, which was great, so he was really trying to address the physiological, but the questions and how I feel like he missed these red flags that he could have found … yeah. So those are the things … his approach and not asking the right questions. I just wish he would have asked the right questions. (personal communication, March 9, 2020)

Ability to Discuss Sex

All participants indicated that though not mandatory, it would be preferable and helpful for a therapist to have a solid understanding of sex or sexuality. Although each client sought therapy for different reasons, they shared that sex came up at some point during the therapeutic relationship.

Sonia. Sonia shared how her therapist addressed the issue of sex during therapy through the lens of intimacy and relationships:

> I feel like what she has helped me with is not necessarily sexual intimacy, but it's more of a relationship intimacy. She did not use any specific terminology. She just kind of…I think she sees intimacy as part of sex and sexuality. She's a couple's therapist too, so I think she's knowledgeable in that arena so she kind of marries the two together. (personal communication, April 3, 2020)

When asked about who brought up the topic of sex or intimacy, Sonia shared:

> I think it was introduced by her, actually. I think she picked up on the fact that I had so many walls up and was so guarded around it, but also yet so wounded, that she, very skillfully, coached me with intimacy and has taught me to stand on my own two feet and be strong and create my boundaries, but I don't have to be walked all over. (personal communication, April 3, 2020)

Brandy. Brandy reported it was difficult talking with her therapist about sex. She stated that her therapist's lack of exploration made it harder for her to push further into what she wanted to talk about. She described constantly "throwing up red flags" and that in retrospect, she wished her therapist had further explored these red flags to help her work through them. Brandy explained that her therapist appeared uncomfortable talking about anything sex related:

> It was usually like, 'So, do you have sex?' Like a really … it was usually like, 'So yeah, do you have sex or do you want to talk about it?' And just kind of like that. Like really awkward. It didn't feel natural in any way. If they were a salesman, they would have failed at their job. Yeah, I just remember not feeling understood and not seen and like, 'Why would I even want to talk with you about sex if you don't even' You know what I mean? There was no established rapport there. (personal communication, March 9, 2020)

Jason. Of the six participants in this study, Jason appeared to have the most gratifying experience discussing sex with his therapist. He shared that he sought therapy to address issues surrounding sex and relationships, and that he felt these needs were addressed adequately with his therapist. Partly, this appeared due to Jason's own ability to discuss sexuality in ways that some might find awkward. He shared that his therapist was also willing to do the same and ask questions when they did not understand something that Jason was addressing:

> I was hoping for dialogue about standards, which is awkward, because what I really wanted is—I wanted to understand where I could stand and how I could have a positive impact in every life around me with more understanding about the social impact that my sexuality could have on another person or another group. I think that I expected that from my psychologist, and I think that I got that, entirely. Because they were like, able to explain and illustrate to me how machismo or misogyny or traditional male roles were impacting dialogue, work dynamics … like all of these different angles. And at the same time, helping me to reestablish sort of a sacred place for people to be around me, if that makes sense.
>
> It takes two to have a dialogue about it, and the psychologist never attempted to be fully literate in anything. If there was something that they didn't understand, believe me they would stop. And it would change that they would stop and say, 'You know, I don't actually know what that is. I don't know what that … why would anyone be into gasping. Why would anyone do any … like, what is it?' For a psychologist to say that all of a sudden, puts both people on the same level. And its patient respect and doctor, or medical professional respect where you have that open dialogue and then all of a sudden, it's a much easier two-way path of communication and learning mutually. (personal communication, November 22, 2020)

Failure to Discuss Sex

Four of the six participants described their therapist as having difficulty discussing sex at some point during their therapeutic relationship.

Sue. Sue shared that having a therapist who did not "have the language" to talk about sex was difficult. And when Sue brought up sex, she felt her therapist was judgmental in her response:

> I had met someone and it wasn't very long into the relationship that we were sexually active, and the faces she was making made me feel that she was judging me about it. And the longer we worked together, the more I understood that she had kind of a … she had a really relational way of thinking about … she does have a really relational way of thinking about sex where you have to jump through some hoops … you have to know each other for a particular amount of time … it's kind of like the rules.
>
> She doesn't talk about sex, really, with me, but she does talk about money. I think those two are equal representations of your sense of personal value. Like how you understand your sexuality or your own sexual behavior and how you understand what you should be making and what you should be spending and what you should earn and how you should manage your resources and all of that. I see so many similarities between those, and I know that when I have conversations with her that she doesn't really know how to have, I can refer to some of the other conversations for ways of thinking about stuff that I can transfer and apply.
>
> There's a lot more openness about identity in general [in society today]. So, it was kind of strange to find somebody who had that conservative feeling about [sex], but then the longer I got to know her, the more I realized it really was what she believes is important for attachment. Less about values or, you know, you shouldn't do that or something like that. But at the time I didn't feel like that … I felt really judged. (personal communication, May 14, 2020)

Amy. Amy stated she and her therapist rarely discussed sex or gender together. When bringing up her own questions about her gender or sexual expression, Amy said her therapist never took time to ask many questions or create space to explore the subject:

> I'm not sure he was aware or not of the difference between gender expression or gender identity and how it relates, or does not, to sexuality. We never really went into it, even if I brought up that I was questioning. (personal communication, February 26, 2020)

Brandy. Brandy said talking about sex with her therapist was difficult. She discussed feeling awkward when sex was a topic of discussion, somewhat due to him not having the ability to overcome his own awkwardness with sex:

> Specifically, talking about … like extreme reactions to asking about sex. Like I had really extreme, super defensive, 'No, not me' I remember constantly sharing needing to be

> beautiful and talking a lot about the male gaze. He did not really respond to that. (personal communication, March 9, 2020)

When Brandy started exploring her sexuality outside of therapy, she shared that she felt comfortable doing so with her therapist:

> I remember having a fear of sharing that I was gay at the time. At the time I was like, 'Oh, I'm bi or whatever.' I didn't … I think I had kind of leaded towards that, and then he … I put out some code words to see if he was picking up what I was putting down and it was like, nothing with that registered. So, that didn't go well. I also recognize there are some providers that just specialize in certain types of things … not everyone can be a great gay therapist. (personal communication, March 9, 2020)

CHAPTER V: DISCUSSION

To begin this study, I selected a random sample of 25 PsyD programs across the United States to evaluate if they offered courses in human sexuality. Of these 25 programs, two offered an elective in human sexuality, which was not required for program completion. This sample, although small, suggests that there is little training, if any, available in PsyD programs across the United States.

Next, I conducted a literature review to explore the needs of clients. The information I found indicates that a wide range of individuals would like psychologists to have some basic knowledge of how to discuss sexuality. This range includes people of different cultural backgrounds, abilities, and sexual orientation. Clinicians who are not adequately trained in human sexuality may risk harming clients from the LGBTQIA community with biases or microaggressions. Depression, anxiety, and PTSD are a few of the diagnoses that may impact a client's sexual function.

I interviewed a small sample of clients to gather information regarding their experiences of discussing sexual issues with their psychologist. The participants shared a range of experiences. They reflected that although some therapists might be willing and able to explore these issues, no specific training was apparent to them. Some participants indicated that, in fact, their therapist's incompetency was damaging to the therapeutic relationship.

Participants who volunteered to be interviewed in this study resided on the West Coast of the United States and ranged in age from 25 to 50. Each participant discussed sexual issues in some capacity with their therapist. Participants were predominantly white and ranged in various sexual and gender identities.

Interviews were semistructured and lasted 45–60 minutes each. Six interviews were completed with participants who met the inclusion criteria. Two additional participants were unable to complete interviews, one due to the timeline of the study, and the second because her therapist was at a master's degree level, therefore, neither met the necessary inclusion criteria.

I then transcribed, coded, and analyzed the data with the application of an IPA research method. From the sum of this data, three primary and eight subthemes emerged. The primary themes included: Experiences of Support, Relationship with Clinician, and the Discussion of Sex/Sexuality. I presented these themes as case studies, often using verbatim quotes pulled from the transcripts to give voice to each individual participant.

Primary Themes

Experiences of Support, the first theme, provided insight into participants' negative and positive experiences of therapy. The second theme, Relationship with Clinician, yielded information about the relationship between the client and therapist, as well as communication and connection in the therapeutic relationship. Finally, participants' narratives revealed how capable they felt their therapists were at broaching the topic of sex and sexuality, as in the theme Discussion of Sex/Sexuality.

Experiences of Support

Experiences of Support represented participants' overall feelings regarding their therapeutic experience.

Satisfying Experiences. Three of the participants shared some positive stories from working with their therapist. The first participant shared that overall, he felt his entire experience working with his therapist was positive. He shared that his therapist was able to meet him where he needed, and that his therapist was able to admit his shortcomings to learn from him as a client.

He shared that this example set forth by his therapist helped in teaching him to ask for help when needed and allowed for growth within the therapeutic relationship.

The second participant shared that overall, her therapist offered her the support she needed. This participant had been with her therapist for over a decade, and felt her therapist helped her through various issues throughout the years. She shared that her therapist was especially supportive when working through issues resulting from childhood trauma. These issues included problems with intimacy in her marriage, which she felt her therapist was skilled at helping her find resolution. The third participant shared times that her therapist was most helpful, especially when she felt her therapist was being what she called “intentional” (Sue, personal communication, May 14, 2020).

The last two participants shared varied stories of both positive and negative experiences. Throughout each of their interviews, these participants shared stories of ruptures they felt their therapists created.

Unsatisfying Experiences. Participants shared unsatisfying experiences of support as well. One participant expressed feelings of discomfort while working with her therapist, as she felt he neither believed or supported her when she discussed sexual trauma or sexual experiences. She further noted that her clinician would fact check her reported experiences of sexual trauma instead of holding her experiences as truth and offering support. In reflection, she stated she felt failed by her therapist.

Relationship with Clinician

Participants indicated that their therapists provided communication, trust, and support. They also reported times they felt their therapist did the opposite. All participants reported how important they felt boundaries were in therapeutic relationship. Some participants shared their

clinician provided good boundaries, while others reported never feeling there were boundaries established.

Respect played an important role in the therapeutic relationship. One participant noted feeling disrespected by her therapist while sharing a difficult emotional experience. Another shared that although there was respect present in the relationship with her clinician, she felt it was more due to the age and gender difference, as well as the fact that he was an expert, which she felt demanded her respect.

When it came to trust, one participant stated they only felt trust and safety with their therapist because of the laws of HIPAA. They noted that this influenced how they shared information with their clinician, in combination with feeling mistrusting toward their clinician, who often questioned their experiences. Another participant noted that although at times there were ruptures in her trust with her therapist, for the most part she felt trust between her and her therapist. All other participants expressed strong feelings of trust in the therapeutic relationship.

Discussing Sex/Sexuality

Some participants felt their clinicians were able to discuss sex and sexuality, while others did not. One participant noted although her clinician broached the topic of sex, it was formal and with little room for exploration. She expressed regret in not being comfortable herself enough to suggest further exploration, and felt her therapist shut her down.

All participants reported that their clinicians did not take a sexual history of any kind during intake, and that when sex was discussed in therapy, it was because they brought it up with their therapist. Some participants reported comfort in doing so, with a receptive clinician who was willing to explore the topic. Others indicated they felt uncomfortable in bringing up the

topic. Only one participant noted feeling complete comfort when discussing their sexuality and sexual experiences, noting that their clinician asked clarifying questions with ease.

Limitations

A few limitations of this study include using a qualitative approach and small sample size. Qualitative research is neither easily replicated nor generalizable (Smith et al., 1999). Phenomenological inquiry allowed me, as a researcher, to view the data through my own lens, placing on it my own experiences and perspectives. Another researcher may have viewed the data differently or chosen different aspects of the information collected.

A small sample size may allow a researcher to get a more in depth look into each participant's story, albeit a limited lens. This limited number of participants could overlook a wider range of individuals from varying backgrounds. Using a larger sample might allow for a more in depth and inclusive collection of data.

Future Action and Research

All participants adamantly agreed that more attention should be paid to sexuality in psychology. They all suggested clinicians, including their own, would benefit from receiving training in sexuality, therefore creating a more open and comfortable environment to discuss sex. A few participants suggested they would have benefitted from their therapist initially opening a conversation introducing sex, allowing the opportunity to explore the topic further. Since it is unknown whether the clinicians referenced in this study received any training in human sexuality, future research might include a broader sample of participants who have worked with clinicians with human sexuality vs. clinicians who do not have human sexuality training.

The literature showed that decreased sexual function negatively impacts quality of life for many individuals. Laumann et al. (1999) purport that sexual dysfunction is a concern of public health. I believe it is important that PsyD training programs offer or require training in sexuality so that psychologists may be adequately trained to work with clients with an array of sexual issues.

The findings of this study suggest that not enough PsyD programs offer training in sex and sexuality. Training in graduate school could influence how psychologists treat emotional distress caused by sexual trauma, as well as assist in exploring clients' intersectionality of sexuality with other identities (e.g., race, disability, religion). Such exploration is important for culturally responsive counseling, which has been linked with higher client satisfaction (Wong et al., 2013).

As stated by Day-Vines et al., (2018) “acknowledgment of cultural factors enhances counselor credibility, client satisfaction, and the depth of client disclosure” (p. 89). This means, when a psychologist is comfortable acknowledging various aspects of a client’s identity,

including sex and sexuality, a stronger clinical relationship may be formed. Therefore, the comfort afforded by the clinician provides an opportunity for a client to discuss topics that may be otherwise difficult to broach. If PsyD programs offered or required sexuality training, it could assist in preparing psychologists to talk about these cultural factors, including sex and sexuality.

The sample used in this study was small and based in one region of the United States. Another study might use a larger sample and include subjects from across the United States. This larger collection could offer more data and diverse range of experiences.

Future research could involve the voice of clinicians, focusing on their viewpoint of training on sexuality, and the implications it has on their practice. This, combined with a broader voice of clients, could offer strong support for creating sexuality training in educational institutions.

Implications

The findings of this study may offer valuable steps toward increasing clinical competency for psychologists. Information in this study suggests that there are vast reasons a client might require a clinician to be comfortable and trained to discuss sex, not only on a global level, but also in more specific terms. This study suggests that the lack of PsyD programs offering human sexuality training is affecting the ability of a clinician's awareness, comfort, and competency when discussing sex, adding to the possibility of ruptures in the therapeutic relationship. Subsequently, future psychologists would benefit if the APA included human sexuality training in the course requirements for accredited programs.

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Appendix A

Inclusion Questions

I will ask a set of questions in order to assess participants meets the inclusion requirements. These questions include:

1. Are you over the age of 18?
2. Have you attended therapy with a licensed psychologist within the last five years?
3. Did you discuss sex or sexuality with your clinician? If not, did you want to but not feel comfortable or safe in doing so?

Participant Questions

Interviews will be semi-structured, starting with an initial question and using predetermined prompts as needed. Room will be made for other questions that arise during interviews. If participants verbalize a history of more than one therapist, they will be asked to focus on the one that felt most influential.

1. What was your initial reason for seeking therapy?
2. What is your gender identity? Sexual orientation?
3. How did sexuality or sex issues relate to your reason for therapy? How did you hope your psychologist would respond to that need? How did they respond?
4. How was the topic of sexuality introduced, and by whom? What was the context surrounding it?
5. Was your therapist knowledgeable, comfortable, and aware?
    a. What kind of terminology did they use when discussing sexuality?
    b. What was your experience around feeling safe?
    c. Can you tell me about how you feel about respect in your relationship with your psychologist?
    d. What were boundaries like between you and your psychologist?

6. In what ways did therapy provide you with something you feel was not available from family and others?
7. How well do you feel your needs and goals were met by your therapist?
8. How do you feel about your therapeutic relationship?
9. What do you feel went well for you in therapy? What did not?
10. What might have made for a better experience?

Appendix B

PsyD Programs

This is a list of the 25 PsyD programs I reached out to and inquired about whether they offered trainings in human sexuality.

ProgramDo They Offer Sexuality Training

1.Northwest University, Seattle WA. No

2.George Fox University, Newberg, ORNo

3.Alliant International University, San Francisco, CANo

4.Antioch University, Seattle, WANo

5.Adler University, Chicago, IL No

6.Marywood University, Scranton, PA No

7.Wright State University, Dayton, OH No

8.Regent University, Virginia Beach, VANo

9.Biola University, La Mirada, CA No

10.University of Hartford, West Hartford, CT No

11.Florida Institute of Technology, Melbourne, FLYes, Elective

12.Georgia Southern University, Statesboro, GANo

13.Midwestern University, Downer's Grove, IL Yes, Elective

14.University of La Verne, La Verne, CA No

15.Chestnut Hill College, Philadelphia, PA No

16.Azusa Pacific University, Azusa, CANo

17.The Wright Institute, Berkeley, CA No

18.La Salle University, Philadelphia, PA No

19.George Washington University, Washington DC. No

20.Widener University, Chester, PA No

21.Indiana State University, Terre Haute, IN No

22.Palo Alto University, Palo Alto, CA No

23.University of Edner, Denver, CO No

24.Baylor University, Waco, TX No

25.Loyola University Maryland, Baltimore, MD No