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Counselor Discomfort with Sexual Issues and Supervisory Role

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Counselor Discomfort with Sexual Issues and Supervisory Role

by

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A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy
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Keywords: sexuality in counseling supervision, sexuality counseling, sexuality countertransference, counseling supervisory support, sexuality discomfort

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Dedication

This dissertation is dedicated to my husband. All the way back in 2004, he supported my desire to leave a corporate job that paid fantastically well but was killing my soul. He made many sacrifices in lifestyle, about which he never complained, instead dismissing them with “but you’re happy.” He also made many sacrifices of time, as he now had a wife who was running a private practice, a full-time doctoral student, and an instructor. All of those evenings I would return from teaching class and literally could not put a sentence together…he was gentle and supportive, never demanding. I could not have done this without him. He is my heart and my family. What the universe takes in some areas it blesses in others. He is my blessing.

I would also like to thank my committee: Dr. Herbert Exum, for keeping me calm and helping me to process things in a reasonable and logical manner (including some rather creative methods), and for allowing me to enter the program in the first place despite flubbing the interview; Dr. Debra Osborn, for her encouragement and positivity, and for really caring about my development; Dr. Barbara Shircliffe, for her support and thought-provoking comments; and Dr. Dinorah Martinez-Tyson, for her enthusiasm and passion, which have been a great motivator for me.

I truly feel blessed for having been able to take this journey.
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Abstract

Sexual issues are common among the general population; therefore it is likely that clients suffer with them whether or not they are presenting issues. Because unresolved sexual issues may contribute to harm, counselors have an ethical obligation to ensure these issues are addressed during therapy. Yet, many fail to do so for a variety of reasons. Because clinical supervisors are in a unique position to nurture and mentor novice counselors, their influence is salient to this issue.

Although some research has been done to address this issue, results are inconclusive and somewhat contradictory. This study attempts to fill in the missing data and to address some of the discrepancies by exploring how counselors perceive addressing sexual issues, identifying some of the influencing factors that allow this issue to persist, and exploring how clinical supervisors can be supportive.

Sixty-three mental health professionals from the state of Florida participated in a survey where they were asked about both their experiences as clinicians and as interns under supervision. Both quantitative and qualitative data were collected, and descriptive statistics, as well as chi-square test of independence were calculated. The degree to which counselors reported being very comfortable with addressing clients’ sexual issues did not align with the reported frequency of initiation of the topic nor the reported levels of discomfort on specific sexual topics. Comfort levels related to discussing sexual issues were found to be positively associated with frequency of
initiation, and in couples cases, female counselors raised the topic significantly more often than male counselors. Other findings are analyzed and discussed, conclusions are drawn, and recommendations for future study and implications for the field are included.
Chapter 1:

Introduction

Sexual issues and concerns are fairly common among the general population in the U.S. In the United States, 43% of women (Shifren, Brigitta, Russo, Segreti, & Johannes, 2008) and 31% of men (Laumann, Paik, Rosen, 1999) suffer from sexual dysfunction. More specifically, twenty-two percent of men over the age of 40 in the U.S. suffer from Erectile Dysfunction (Laumann et al., 2007), and 27% of men suffer from early ejaculation (Laumann et al., 2005).

Despite the prevalence of these issues, clinicians are often ill prepared to address them (Haboubi & Lincoln, 2003; Harris & Hays, 2008; Juergens, Smedema, & Berven, 2009; Kazukauskas & Lam, 2010; Papaharitou et al., 2008; Weerakoon, Jones, Pynor, & Kilburn-Watt, 2004). As a result, many clients may not have their sexual issues resolved, possibly resulting in unhappiness and a reduction in well being (Blanchflower & Oswald, 2004; Laumann et al., 2006). Because mental health, marriage and family, social work and psychology interns must undergo a period of clinical supervision, clinical supervisors are in a unique position to assist and support pre-licensed counselors in this area.

Background of the Problem

The counseling profession is unique in that most of the clinical work occurs within an interpersonal relationship between the counselor and client. Likewise, most of the
supervisory work occurs within the relationship between counselor and supervisor. As such, in order to understand why sexual issues are not being addressed in the counseling relationship, it is essential to consider the interpersonal dynamics between counselor and client. Similarly, in order to understand how supervisors can support clinicians in addressing their clients’ sexual issues, it is essential to consider the interpersonal dynamics between counselor and supervisor.

The emphasis on clinical supervision is the hallmark of the counselor education field. The process of counseling is complex, and extensive supervision is required to not only guide and prepare novice clinicians, but also to model appropriate techniques to address issues that arise during their counseling experiences. One of the important themes in clinical supervision is the productive management of counter-transference and other uncomfortable feelings that may arise during the therapy process. Many topics may trigger intense feelings among counselors, but the research base suggests that sexual shame is particularly potent (Mollon, 2005; Shadbolt, 2009).

Sexual shame is defined as a more enduring form of embarrassment about sexuality or sexual issues. It is “associated with the desires and other aspects of the self that are not allowed access to shared discourse” (Mollon, 2005, p. 168). Sexual shame is manifested by avoidance or difficulty in talking about the topic (Shadbolt, 2009).

Despite the sexual revolution and the subsequent sexual liberation experienced in the past decades, particularly the 1960s (Irvine, 2009), American society still views sexuality as “the paradigmatic object of shame and repression” (Mollon, 2005, p. 167). Many factors have been identified in the sexual health literature that contribute to
negative feelings about sexuality. These include (a) having a sexually transmitted disease (Foster & Byers, 2008); (b) lack of sexual education (Goldman, 2008); (c) culturally based negative view of sexuality (Harris & Hays, 2008; Schneider, 2002; Schneider, 2005); (d) religiously based constriction of sexuality (Ahrold & Meston, 2010; Baier & Wampler, 2008; Barkan, 2006; Daniluk & Browne, 2008; Hull, 2008; Kwee & Hoover, 2008; Papaharitou et al., 2008); (e) childhood sexual abuse (Sorsoli, Kia-Keating, & Grossman, 2008; Træen & Sørensen, 2008); (f) negative view of menstruation (Schooler, Ward, Merriwether, & Caruthers, 2005); and (g) being female (Papaharitou et al., 2008). Although all these factors contribute to negative feelings about sexuality, religiously based constriction appears to be most often cited.

Of all the possible causes of sexual shame, the literature base seems to suggest adherence to conservative religious beliefs most often (Ahrold & Meston, 2010; Baier & Wampler, 2008; Barkan, 2006; Daniluk & Browne, 2008; Hull, 2008; Kwee & Hoover, 2008). Although some religions, such as Hinduism and Buddhism, support sexuality in a positive and open way, many religions based on the Bible, Torah or Qur’an may offer a more constricted and patriarchal view (Daniluk & Browne, 2008). As a result, it may be possible that some women may tend to feel more shameful about sex than men. Thus, it is commonly thought that there is an inverse relationship between adherence to conservative religious beliefs and sexual openness (Ahrold & Meston, 2010; Baier & Wampler, 2008; Barkan, 2006; Daniluk & Browne, 2008; Hull, 2008; Kwee & Hoover, 2008).

This suggests that people who strongly follow very conservative religious rules may be less likely to report engaging in certain types of sexual behaviors because those
behaviors are perceived to be “wrong” (Barkan, 2006; Hull, 2008). Two specific examples stand out from the literature. First, most Judeo-Christian religions tend to place a stigma on male masturbation (Kwee & Hoover, 2008) because it is not required for procreation, and procreation is the main purpose of sexual activity (Daniluk & Browne, 2008), according to most conservative Christian religions. It is noteworthy that female masturbation is not addressed.

Second, homosexuality appears to be particularly problematic. Although there are individual differences, in general, fundamentally religious persons tend to have a negative view of gay sexual activity (Hunsberger & Jackson, 2005; Schwartz & Lindley, 2005). This is true for Christian (Burdette et al., 2005; Wilkinson & Roys, 2005), Jewish (Antar, 2012) and Muslim (Bonthuys & Erlank, 2012) belief systems. Among the Christian religions, it appears that Protestants may have the most negative views of gay sexual activity (Burdette et al., 2005). It follows then that conceptualizing any sexual behavior outside procreation as wrong is likely to lead to a more generalized sense of shame regarding sexuality. Therefore, sexual shame may be more likely among fundamentally religious people. A more detailed discussion of this topic will be presented in Chapter 2.

Many counselors report that sexual concerns are a common therapeutic issue (Harris & Hays, 2008). According to a 2008 study of over 30,000 U.S. women, 43% of the female population suffers from sexual problems (Shifren, Brigitta, Russo, Segreti, & Johannes, 2008). Laumann et al. (1999) found the same percentage in a national study of 1749 women and 1410 men aged 18 to 59 years. More specifically, according to a 2005 global study of 13,882 women and 13,618 men aged 40 to 80 years from 29
countries, including women from the non-European West (Australia, Canada, New Zealand, South Africa, and the U.S.), the two most prevalent sexual issues for women are low desire (32.9%) and inorgasmia (25.2%) (Laumann et al., 2005). Lastly, Nusbaum, Gamble, Skinner, and Heiman (2000) found that 98% of women reported sexual concerns to their doctor during a routine gynecological visit.

Men seem to have similar but possibly lower rates of sexual issues. A 2005 global study, including men from the Australia, Canada, New Zealand, South Africa, and the U.S., found that the two most common sexual problems for men were premature ejaculation (27.4%) and erectile dysfunction (ED) (20.6%) (Laumann et al., 2005). A 2002 review of 23 global studies reported the prevalence of ED as ranging from 2% in men younger than 40 years, and 86% in men 80 years and older (Prins, Blanker, Bohnen, Thomas, & Bosch, 2002). A 2001 nationally representative survey found ED at an average rate of 22% (Laumann et al., 2007). Laumann et al. (1999) found the overall rate of male sexual dysfunction in general to be 31%, whereas Levy (1994) reported it at 50%.

**Clinician deficiencies.** Because sexual issues are so common, it follows that therapists who perform in-depth psychotherapy should be prepared to address them. However, even though human sexuality is one of the required knowledge domains for couple and family therapists (CACREP, 2009) and is a requirement in many states for mental health counselors, many counselors are still not adequately prepared to address clients’ sexual issues (Haboubi & Lincoln, 2003; Harris & Hays, 2008; Juergens et al., 2009; Kazukaukas & Lam, 2010; Papaharitou et al., 2008; Weerakoon et al., 2004). As a result, despite the great need, clients’ sexual issues are generally not addressed
(Harris & Hays, 2008; Juergens et al., 2009; Kazukaukas & Lam, 2010; Papaharitou et al., 2008).

For example, one study found over 50% of health professions students ($N = 1132$), including medical sciences ($n = 1009$), rehabilitation counseling ($n = 63$), leisure and health sciences ($n = 39$), and behavioral science ($n = 19$) were uncomfortable discussing sexuality with patients (Weerakoon et al., 2004). Clinician discomfort and ignorance could lead to misperceptions, misinformation, and negative outcomes for the client. For example, many counselors may share a common misperception that persons with a disability are asexual (Juergens et al., 2009). However, unresolved sexual issues can affect self-esteem, particularly for clients with a disability (Juergens et al., 2009).

Also, clients generally expect counselors to be the experts, when in reality some counselors may know less about an issue than their clients (Harris & Hays, 2008). Because counselors are perceived as experts, clients may wait for the counselor to raise the topic. However, many counselors may not broach the topic due to their own discomfort and lack of knowledge, so the topic may not be addressed. Despite these challenges, a substantial portion of the supervisors studied by Decker (2010) recommended that clients’ sexual issues should be considered in treatment.

**Statement of the Problem**

The plethora of data on sexual shame in the sexual health literature combined with the commonality of sexual issues among clients illuminates a problem that affects many people. Although some individuals may seek counseling to resolve their sexual concerns, many counselors are not adequately prepared to assist them. As a result,
sexual issues are generally not consistently addressed in counseling. Further disservice can be done if counselors shame their clients by allowing their own discomfort to be expressed orally or nonverbally within sessions. Lastly, clinical supervisors are in a unique position to help.

**Purpose of the Study**

The purpose of this study is to explore the experience of clinicians addressing clients’ sexual issues within the context of the counseling relationship, as well as within the supervisory relationship.

The objectives for this study include to:

1. Learn how counselors are addressing sexual issues with their clients;
2. Learn more about the sources of discomfort counselors may have regarding addressing sexual issues with their clients;
3. Understand how the clinical supervision process influenced the counselor in addressing clients’ sexual issues; and
4. Understand the barriers and facilitators experienced by counselors that influenced clinical supervisory support in addressing clients’ sexual issues.

**Significance of the Study**

Although researchers seem to agree that a lack of knowledge and negative personal feelings, including shame and embarrassment about sexuality, are the two main reasons counselors fail to address the topic with their clients (Haboubi & Lincoln, 2003; Harris & Hays, 2008; Juergens et al., 2009; Kazukauskas & Lam, 2010; Papaharitou et al., 2008; Weerakoon et al., 2004), there is little confirming empirical evidence. There is also confusion as to the etiology of the discomfort.
Because of their role in helping counselors overcome (their own) resistance to establish their comfort level with various issues, clinical supervisors are in a unique position to help. There should be a wealth of data related to how counselors perceive their supervisors as helpful in overcoming their resistance to addressing clients’ sexual issues. Yet, there is a dearth of research in this critical area: “Clinical supervision for sexual issues is an understudied area in the literature” (Decker, 2010, p. 19).

Research Questions

More specifically, this study seeks to address the following questions:

1. What are counselors’ perceptions regarding how well they address their clients’ sexual issues?

2. What is the relationship between counselor comfort with clients’ sexual issues and: counselor frequency of initiating sexual discussions, counselor professional identity, counselor gender, and counselor religious fundamentalism?

3. What are counselors’ perceptions regarding supervisory support in addressing sexual issues with their clients?

Research Hypotheses

Several researchers (Haboubi & Lincoln, 2003; Harris & Hays, 2008; Juergens et al., 2009; Kazukauskas & Lam, 2010; Papaharitou et al., 2008; Weerakoon et al., 2004) have suggested that the reason counselors are failing to address clients’ sexual issues is due to shame or embarrassment about sexual topics. Thus, it is expected most counselors feel uncomfortable addressing their clients’ sexual issues.

Berman (1996) and Harris and Hays (2008) found that comfort increased willingness. It logically follows that if counselors are more willing to address sexual
issues, they will initiate sexual discussions with their clients. Thus, a positive relationship between comfort and initiation of the topic is expected.

Another factor that would increase both comfort and willingness is the professional identity of sex therapist. Because knowledge increases willingness (Berman, 1996; Harris & Hays, 2008) sex therapists would be more likely to initiate these types of conversations because of their specialized training in sexology. They are also more likely to be comfortable.

With regard to gender, although the findings in the literature base are mixed, with Fluharty (1996) finding females more comfortable with sex topics, Berman (1996) and Decker (2010) finding no difference, and Ford and Hendrick (2003) and Haag (2009) finding male therapists more comfortable, it is the opinion of the author that female counselors will be more comfortable with sexual topics because female sexuality is more fluid and more diverse.

Regarding religion, because some researchers (Ahrold & Meston, 2010; Baier & Wampler, 2008; Barkan, 2006; Cowden & Bradshaw, 2007; Daniluk & Browne, 2008; Gravel, Young, Olavarria-Turner, & Lee, 2011; Hull, 2008; Kwee & Hoover, 2008, Papaharitou et al., 2008; Schwartz & Lindley, 2009) have found a link between religious fundamentalism and discomfort with sexual topics, it follows that counselors who are religiously fundamental will uncomfortable with sexual topics. Thus, a negative relationship between comfort and religious fundamentalism is expected.

Lastly, because counselors are failing to address clients’ sexual issues (Harris & Hays, 2008; Juergens et al., 2009; Kazukaukas & Lam, 2010; Papaharitou et al., 2008) and supervisors are in a unique position to support and educate supervisees (Heru,
Strong, Price, & Recupero, 2004; Heru, 2006), it is expected that participants will report that their supervisors did not support them adequately in addressing their clients’ sexual issues.

Therefore, the tentative hypotheses for this study are as follows:

\[ H_0: \] Most counselors do not feel uncomfortable addressing their clients’ sexual issues.

\[ H_1: \] Most counselors feel uncomfortable addressing their clients’ sexual issues.

\[ H_0: \] No relationship exists between counselor comfort with clients’ sexual issues and the following: counselor frequency of initiating sexual discussions, counselor professional identity of sex therapist, counselor gender of female, and religious fundamentalism.

\[ H_2: \] There will be a positive relationship between counselor comfort with clients’ sexual issues and the following: counselor frequency of initiating sexual discussions, counselor professional identity of sex therapist, and counselor gender of female; and a negative relationship between counselor comfort with clients’ sexual issues and religious fundamentalism.

\[ H_0: \] Counselors do not feel unsupported by their supervisors in addressing clients’ sexual issues.

\[ H_3: \] Counselors feel unsupported by their supervisors in addressing clients’ sexual issues.

**Conceptual Assumptions**

Systemic theory (Beckvar & Beckvar, 2006; Corsini & Wedding, 2008) provides an elegant way of understanding the interpersonal dynamics between counselor and
client as well as clinical supervisor and counselor. In systemic theory, a concept is understood primarily by how other factors influence it. Because many factors can influence the personal dynamics between counselor and client, such as sexual shame, systemic theory is a natural fit in the conceptualization of the failure of counselors in addressing clients’ sexual issues.

In addition, the effects of larger systems, such as family and society, should be considered. Rampant sexual shame, originating within either the family of origin, the church, or society is one possible origin of this problem that can be conceptualized using systemic theory. Systemic theory provides a framework that represents the counseling dyad as a subsystem of such factors. For these reasons, systemic theory as posited by Beckvar and Beckvar, 2006, and Corsini and Wedding, 2008 will be used as the theoretical framework for this study.

*Figure 1:* Factors affecting discussion of clients’ sexual issues.
Conceptual Framework

The reluctance to discuss sexual issues with clients can be conceptualized as a system (Figure 1). The counseling dyad, consisting of the counselor and the client, and the sexual discussions between them, form this system. External factors, such as client gender, sexual topic (Palma & Stanley, 2002; Rutter et al., 2010) and supervisory support (Berman, 1996; Harris & Hays, 2008; Hays, 2002) may affect this system.

In addition, internal factors such as counselor comfort level with sexual topics (Harris & Hays, 2008; Hartl et al., 2007; Juergens et al., 2009; Papaharitou et al., 2008; Ridley, 2006; Weerakoon et al., 2004; Weerakoon et al., 2008) also can affect this system. Thus, internal and external factors may affect whether discussions about sexual issues take place within the counseling dyad.

![Diagram](image)

**Figure 2**: Internal factors affecting comfort level.
Figure 2 depicts the internal factors affecting personal comfort level with sexual issues. Comfort level is comprised of factors within the counselor or supervisor that can affect the ability to discuss clients’ sexual issues, including religious fundamentalism (Ahrold & Meston, 2010; Baier & Wampler, 2008; Barkan, 2006; Cowden & Bradshaw, 2008; Daniluk & Browne, 2008; Gravel et al., 2011; Hull, 2008; Kwee & Hoover, 2008, Papaharitou et al., 2008; Schwartz & Lindley, 2009), counselor gender (Haag, 2009; Fluharty, 1996; Ford & Hendricks, 2003), level of experience with sexual issues (Arnold, 1980; Harris & Hays, 2008) and professional knowledge regarding sexual issues (Berman, 1996; Harris & Hays, 2008; Juergens et al., 2009; Kazukauskas & Lam, 2010; Papaharitou et al., 2008; Post, Gianotten, Heijen, Hille Ris Lambers, & Willems, 2008; Simpson, Anwar, Wilson, & Bertapelle, 2006; Weerakoon et al., 2008). These internal factors reside within the counselor or supervisor, and form their own subsystem.

Religious fundamentalism may affect counselor or supervisor comfort with sexual issues. Sexual shame is the main contributor to discomfort with sexuality in general (Mollon, 2005; Shadbolt, 2009), and religious fundamentalism is a major contributor to sexual shame (Ahrold & Meston, 2010; Baier & Wampler, 2008; Barkan, 2006; Daniluk & Browne, 2008; Hull, 2008; Kwee & Hoover, 2008). Thus, it follows that religious fundamentalism could affect the ability of counselors or supervisors discuss clients’ sexual issues due to its potential impact on comfort with sexual issues.

Other internal factors include a lack of knowledge regarding sexual issues (Berman, 1996; Harris & Hays, 2008; Juergens et al., 2009; Kazukauskas & Lam, 2010;
Papaharitou et al., 2008; Post, Gianotten, Heijen, Hille Ris Lambers, & Willems, 2008; Simpson, Anwar, Wilson, & Bertapelle, 2006; Weerakoon et al., 2008) and lack of experience related to sexual issues (Arnold, 1980; Harris & Hays, 2008). Counselor or supervisor gender is also a possible contributor, although the research data are somewhat contradictory. Ford and Hendrick (2003), Haag (2009) and Papaharitou et al. (2008) found male counselors more comfortable with sexual topics; Fluharty (1996) found female counselors more comfortable with sexual topics; and Berman (1996) and Decker (2010) found no difference in levels of comfort.

*Figure 3*: External factors affecting discussion of clients’ sexual issues.

Figure 3 illustrates the external factors that can influence discussion of clients’ sexual issues. These include the gender of the client (Cowden & Bradshaw, 2007; Fluharty, 1996; Ford & Hendrick, 2003; Haag, 2009; Papaharitou et al., 2008), the sexual topic itself (Palma & Stanley, 2002; Rutter et al., 2010), and the level of
supervisory support (Berman, 1996; Harris & Hays, 2008; Hays, 2002). Supervisory support is another sub-system, and will be illustrated in the next figure.

**Figure 4:** Factors affecting supervisory support.

Figure 4 represents factors that influence the level of supervisory support with regard to the discussion of clients’ sexual issues. If the counselor can feel discomfort with sexual issues (Harris & Hays, 2008; Hartl et al., 2007; Juergens et al., 2009; Papaharitou et al., 2008; Ridley, 2006; Weerakoon et al., 2004; Weerakoon et al., 2008), it follows logically that the supervisor may experience it as well. Therefore, the comfort level with sexual issues is a major factor affecting the discussion of clients’ sexual issues in the supervisory context. Other factors include the supervisor’s failure
to establish boundaries for supervision (Hartl et al., 2007; Heru, 2006; Heru et al., 2004), and the supervisor not addressing the topic (Hartl et al., 2007; Heru, 2006).

**Definition of Major Terms**

**Discomfort with sexual issues.** Discomfort with sexual issues is defined as the inability to: a) accept and respect clients’ sexual practices, b) have open discussions about clients’ sexuality, and c) communicate effectively regarding sexuality (Graham & Smith, 1984). It is a broad concept involving “cognitive, affective and behavioral responses to sexuality” (Graham & Smith, 1984, p. 439). Being comfortable with sexual issues is a developmental task “influenced by the physiological, psychological, sociological, spiritual or religious, educational and sexual aspects of one’s being.” (Graham & Smith, 1984, p. 440).

**Psychotherapy.** Psychotherapy is the relief of distress in one person by another trained person, using a specific approach or paradigm (Frank, 1963). More specifically, it is the “use of verbal means to influence beneficially another person’s mental and emotional state” (Ebert, Loosen, Nurcombe, & Leckman, 2009, p. 151). This verbal influence occurs in a structured, professional relationship with a qualified person, known as the “therapist” or “counselor.” In this study, the terms “psychotherapy” and “counseling” will be used interchangeably.

**Religious fundamentalism.** Religious fundamentalism characterized by an emphasis on the rigid, narrow views created by focusing on the dogma of religion, rather than its spiritual aspects (Daniluk & Browne, 2008). For example, Christian fundamentalism emphasizes the literally interpreted Bible as the guide to life and is usually associated with Protestant religions (Fundamental, n.d.). The fundamentally
religious believe that, “God gave us a set of flawless religious teachings” that must be followed (Altemeyer & Hunsberger, 1992, p. 126), as opposed to the more spiritually-oriented, whose beliefs are more centered in faith and individual inspiration (Daniluk & Browne, 2008).

**Sexual issues.** Sexual issues are broadly defined as any sexual concern a client may have and the psychological issues that accompany it. Typical sexual issues include: sexual performance, sexual dysfunctions, gender issues, sexual abuse, sexual disorders, sexual addiction, sexual trauma, sexual shame and sexual intimacy issues (LoFrisco & Hicks, 2012).

**Sexual knowledge.** Sexual knowledge is defined as possession of correct information regarding human sexuality, including a good understanding of the dynamics and psychological effects of sexual dysfunctions, information about the sexual response phases, and an awareness of what is considered to be “average” or “normal.”

**Supervisory support.** Supervisory support is defined as the level of encouragement, assistance and information provided by the clinical supervisor related to addressing sexual issues as perceived by the supervisee.

**Scope and Delimitations of the Study**

This study will be limited to examining the experiences and exploring the perspectives of practicing therapists on addressing clients’ sexual issues both while practicing and during their supervision. Therapists will be asked to describe both their counseling and supervisory experiences, including how comfortable they felt when discussing clients’ sexual issues. Although the participants may be counseling supervisors as well as therapists, only their perspectives as therapists will be explored.
Although the perspective of the supervisor is very important, this will not be the focus of this study.

Participants in this study will be limited to mental health professionals who perform psychotherapy with the emphasis on mental health counselors. Psychologists, marriage and family therapists, and licensed clinical social workers will also be included. These types of therapists have the opportunity to do in-depth psychotherapy and have the flexibility to explore sexual issues.

Generalizability of this study is limited for two reasons. First, only participants from the Tampa Bay area of Florida are included. Second, the instrument used was created by the author and has not been standardized. Theoretical perspective is another limitation to this study. Because this issue is viewed through a systemic lens, certain interpersonal factors may have been overlooked, such as unconscious conflict. The topic of “sexual issues” will be limited to sexual concerns of the client. It will not include how counselors handle clients who are sexually inappropriate during sessions, or sexual transference or counter-transference. The sexual orientation of the counselor or supervisor will also not be included as criteria for this study. Although these are all valid concerns, and could negatively affect the counselor’s efficacy, they are outside the scope of this study.

Summary and Overview

Chapter 1 began with the background and significance of the problem. Then, the purpose of the study, objectives and research questions were presented. This was followed by the conceptual assumptions. Chapter 1 concluded with a definition of terms, and an explanation of the scope and delimitation of the study. Chapter 2 opens
with the historical background of the conceptual framework, followed by an in-depth literature review, and ends with a summary. Chapter 3 describes the study design and methodology, including a description of the sample, instruments, data collection procedures, and statistical analysis. Chapter 4 describes the results, and chapter 5 provides the final summary and conclusion.
Chapter 2:

Literature Review

Chapter 2 begins with a reintroduction to the topic, followed by the conceptual framework, including its historical background. Next, a review and evaluation of the present literature on counselor discomfort with clients’ sexual issues and the supervisory role in that discomfort will be presented. The review will begin with a discussion of the factors that influence therapist comfort with sexual topics, including therapist knowledge about sexual issues, therapist gender, particular sexual topics, such as counseling GLBT (gay, lesbian, bisexual transgender) persons, and therapist religious fundamentalism. Next, the role of the supervisor will be discussed, including education on sexual topics, therapist anxiety, supervision boundaries and supervisory alliance. Lastly, a critical evaluation of the literature will be presented, followed by a summary of the chapter and an introduction into the next.

Reintroduction To Topic

Sexual issues are common among the general U.S. population. In the United States, 43% of women (Shifren et al., 2008) and 31% of men (Laumann et al., 1999) suffer from sexual dysfunction. More specifically, twenty-two percent of men over the age of 40 in the U.S. suffer from Erectile Dysfunction (Laumann et al., 2007), and 27% of men suffer from early ejaculation (Laumann et al., 2005). Therefore it is possible that clients seeking counseling services may also have a sexual issue. According to the
literature, therapists are failing to address these issues (Harris & Hays, 2008; Juergens et al., 2009; Papaharitou et al., 2008) although doing so is very important for client well-being (Harris & Hays, 2008; Juergens et al., 2009). Although the literature (Harris & Hays, 2008; Hartl et al., 2007; Juergens et al., 2009; Papaharitou et al., 2008; Weerakoon et al., 2004; Weerakoon, Sitharthan, & Skowronski, 2008) suggests lack of knowledge and discomfort as the reason for therapist reluctance, empirical data are sparse. Furthermore, although the supervisory relationship would be the logical context under which therapists could address their discomfort, there is little research on how supervisors can help.

Possible ramifications of unresolved sexual issues include lower happiness and well-being (Blanchflower & Oswald, 2004; Laumann et al., 2006; Rosen & Bachmann, 2008), and lower motivation in vocational pursuits (Juergens et al., 2009). Despite the commonality of sexual concerns and the above ramifications to clients when these issues are not addressed, counselors routinely fail to address them, possibly due to discomfort and lack of knowledge (Harris & Hays, 2008; Hartl et al., 2007; Juergens et al., 2009; Papaharitou et al., 2008; Weerakoon et al., 2004; Weerakoon et al., 2008).

Therapist silence on sexual issues can be harmful to clients (Blanchflower & Oswald, 2004; Laumann et al., 2006). If the therapist fails to recognize a clients’ concern, clients may get the impression that the topic is taboo (Hays, 2002), and then they will never raise the topic again. Because systemic theory focuses on the interpersonal dynamics of counselor and client, of supervisor and counselor, and how outside factors can contribute to sexual shame, counselor discomfort, and unwillingness to address clients’ sexual issues is best understood in the systemic frame.
**Systemic Theory**

**Origins.** In the 1940s, an Austrian biologist, Ludwig von Bertalanffy, was the first to create a universal theory for living systems. Bertalanffy stated that all systems are subsystems of larger systems, a fact that the modern systems theorist often forgets. Therefore, according to the original conceptualization of systems theory, outside systems such as family and community affect both the dyad consisting of the counselor and client, and the dyad of the counselor and supervisor. In addition, these outside systems affect each individually. Meaning, societal values have an impact on the client, counselor and supervisor in that these values help shape individual comfort levels. Bertalanffy was also the first to state that a system is greater than the sum of its parts, thus revolutionizing our understanding of relationship dynamics (Beckvar & Beckvar, 2006).

**Feedback loops.** Systems theory is primarily based on *cybernetics*. In 1948, MIT mathematician Norbert Wiener developed an internal feedback system to monitor plane speed. Gregory Bateson, one of the many influential systems theorists, started meeting with Wiener beginning in 1942. Wiener influenced Bateson greatly in his development of family systems theory. Similar to planes, the client/counselor and the counselor/supervisor dyads have their own internal feedback system. The term *cybernetics* is a term coined by Wiener (Corsini & Wedding, 2008) to describe systems that operate via internal feedback loops to maintain homeostasis. For example, the operation of a thermostat in summer is based on cybernetics; when the temperature becomes too high, the thermostat signals the air conditioner to bring the air back down to an acceptable temperature (Nichols & Schwartz, 2006). In this context, avoiding
sexual topics is understood as a method of maintaining homeostasis in the dyads. For example, if the client detects any discomfort emanating from the counselor, he or she is likely to avoid the topic that created the discomfort so that homeostasis can be maintained.

Circular causality. Because of cybernetics, systems theorists now understand that events, including psychological issues, occur in a circular fashion (Corsini & Wedding, 2008). Because the parts of the system are interrelated, it is both impossible and unnecessary to determine the origin of an event. More specifically, “Any cause is seen as an effect of a previous cause and becomes, in turn, the cause of a later event” (Corsini & Wedding, 2008, p. 419). Within this frame, avoidance of sexual topics is understood as both a result of previous discomfort and a possible cause of future discomfort. Although there can be individual causes that contribute to the discomfort, and they will be relevant to the problem, the focus is on the interpersonal dynamics and not on the origin of the avoidance.

Systems theory proposes that individual behavior and development is strongly associated with the interactions with others in the system (Corey, 2009). Members of a system, such as a counseling or supervisory dyad, will look to each other for reactions, such as a facial expression or tone of voice, and then base their own feelings and behavior upon those reactions (Corsini & Wedding, 2008). In fact, according to systems theory the individual parts are meaningless when considered separate from the whole (Nichols & Schwartz, 2006). Therefore, it is impossible for the avoidance of sexual topics to originate from within the individual; rather, it is a product of current or past relationship dynamics. More specifically, the discomfort felt by clinicians originated as a
result of either past interactions with family, church or other systems, or current interactions with either their client or supervisor. Furthermore, avoidance of sexual topics can increase if the supervisor or client reacts negatively.

This is not an issue relegated to mental health. Other related fields appear to have similar issues. Specifically, rehabilitation counselors often fail to address sexuality issues, especially with persons with a disability (Juergens et al., 2009). The majority of people with spinal cord injuries report poor sexual adjustment (Juergens et al., 2009). For people with disabilities, sexual esteem is particularly important, more so than for people without disabilities, because it helps increase self-esteem and prevent depression (Juergens et al., 2009). Sexuality in people with disabilities can be one of the more sensitive sexuality topics (Juergens et al., 2009). Counselors must be comfortable with the topic to initiate conversations about sexuality (Juergens et al., 2009).

**Therapist Comfort**

Due to the sensitive nature of the topic, several researchers (Harris & Hays, 2008; Hartl et al., 2007; Juergens et al., 2009; Papaharitou et al., 2008; Weerakoon et al., 2004; Weerakoon et al., 2008) have determined that therapists’ comfort with sexuality must be increased in order for them to be able to address clients’ sexual concerns. Therapists cannot rely on clients to raise sexual issues because that may rarely happen: “It cannot be assumed that clients will initiate a discussion about sexual issues even when it is an area of concern for them” (Hays, 2002, p. 4). Therefore, increasing counselor comfort with this topic is vital, since they may need to take the initiative in addressing these issues with clients.
For example, out of 1132 undergraduate students in health-related disciplines, over half of them reported discomfort with nine out of 19 items on Cohen, Byrne, and Hay’s (1996) Comfort Scale Questionnaire. Of particular note is the finding that 65.1% and 63.8% of the students were uncomfortable asking a client about sexual practice and sexual experience, respectively (Weerakoon et al., 2004).

To increase comfort levels, counselors must be supported in examining and addressing their own subjective sexual views (Ridley, 2006). If counselors are unaware of their feelings and internalized attitudes about sexuality, how can they help clients address theirs? Feelings are important to address, because without feelings, knowledge is misleading (Ridley, 2006). Therefore, increasing counselor comfort with sexuality is important.

Knowledge. Researchers (Arnold, 1980; Berman, 1996; Decker, 2010; Ford & Hendrick, 2003; Haag, 2009; Harris & Hays, 2008; Weerakoon et al., 2008) disagree slightly about the relationship between knowledge and comfort regarding clients’ sexual issues. In addition, there is little empirical research on how willingness to address clients’ sexual issues is increased. Both Harris and Hays (2008) and Arnold (1980) found a significant connection between knowledge and willingness, but not between knowledge and comfort. Decker (2010) did not find a significant correlation between knowledge and comfort, either. Ford and Hendrick (2003) concur, finding that despite receiving training on sexual issues, therapists felt “neutral” about their comfort level.

However, Berman (1996), Haag (2009), and Weerakoon et al. (2008) all found positive correlations between knowledge and comfort. Going further, Berman (1996) found informal means of sexuality education, such as instruction provided during
supervision, more effective than more formal means, such as classroom instruction. Lastly, the two counselors in the Rutter, Leech, Anderson, and Saunders (2010) in-depth case study reported that they needed more training on transgender issues to feel comfortable working with transgendered clients.

Decker (2010) explored the degree to which clients’ sexual issues are considered in the clinical supervision of marriage therapy trainees and interns by studying 103 supervisors from the California Association for Marriage and Family Therapists (CAMFT). Instruments included surveys developed by the author. Findings indicated 50% or more participants felt knowledgeable about content areas related to sexual values or relationships, but less so when sexual issues were the predominant concern (medical illness that affects sexuality: 40.8%; sex and individuals with disabilities: 33%; sexual compatibility: 46.6%; sexual dysfunction: 45.6%; sexual relationship enhancement: 41.7%; and sexual variations [i.e., fetishes]: 31.1%). Fifty percent or more felt comfortable supervising all areas, except sexual variations such as fetishes or Bondage Domination Sadism Masochism (BDSM) (42.7%).

No significant correlations were found between knowledge about sexual issues and comfort with providing supervision on sexual topics ($r(101) = 0.16, p = .10$, two-tailed test). With regard to knowledge, no significant correlations or differences were found with gender ($t(101) = -0.10, p = .92$, two-tailed test), ethnicity/race ($t(100) = -0.09, p = .93$, two-tailed test), sexual orientation ($t(101) = 1.51, p = .13$, two-tailed test), age ($r(98) = 0.11, p = .27$, two-tailed test), religious salience ($r(97) = -0.04, p = .67$, two-tailed test) or spiritual salience ($r(100) = -0.12, p = .25$, two-tailed test).
With regard to comfort, no significant correlations or differences were found with gender ($t(101) = 0.59, p = .56$, two-tailed test), ethnicity/race ($t(100) = 1.05, p = .30$, two-tailed test), sexual orientation ($t(101) = 0.95, p = .35$, two-tailed test), age ($r(98) = -0.00, p = .98$, two-tailed test), religious salience ($r(97) = -0.20, p = .053$, two-tailed test), or spiritual salience ($r(100) = -0.12, p = .23$, two-tailed test).

Decker (2010) eliminated providers certified by the American Association of Sexuality Educators, Counselors and Therapists (AASECT), but not graduates of other sex therapy programs. Therefore, sex therapists could have been included in the sample, introducing possible bias. Another generalizability issue is that all participants were from California. Decker (2010) also eliminated psychologists, social workers, mental health counselors, rehabilitation counselors, and addictions professionals from the sample, leaving only marriage and family therapists, introducing further bias. Also, no reliability measurements were performed on the instrument. Lastly, although Decker (2010) provides some useful information, it is an unpublished dissertation and has not been vetted properly.

The effectiveness of an online course, Sexuality for Health Professionals, was measured in the only experimental study (Weerakoon et al., 2008) of therapist sexual comfort. Sixty-two health professionals enrolled in the online course. Pre and posttest measurements yielded an improvement in comfort level as measured by the Comfort Scale Questionnaire (Cohen et al., 1996) for most items. Specifically, significant improvement was found on the two most general, and therefore most common, items: “answering patients'/clients’ questions on matters relating to sexuality” ($t = 2.394, df =$
Health professionals can vary widely on their willingness to address sexual concerns. An area of weakness in their study was that Weerakoon et al. (2008) did not distinguish medical professionals, who may have less practice and training in discussing sexual issues, with mental health professionals.

**Initiation of sexual topics.** Two major studies examined the role that education, experience and comfort play in initiating sexual topics with clients. In the first study, Harris and Hays (2008) examined to what extent sexuality education and supervision experience, clinical experience, perceived sexual knowledge, and comfort with sexual topics influence if family therapists are having sexuality discussions with their clients. For 175 clinical members of the American Association for Marriage and Family Therapy, therapist sexuality education and supervision experience ($r = .33$) and clinical experience ($r = .26$) had significant direct effects on perceived sexual knowledge. Clinical experience did not have a significant effect on sexual comfort, but sexuality education and supervision experience ($r = .33$) and therapist perceived sexual knowledge ($r = .64$) did. Therapist perceived sexual knowledge did not have a significant direct effect on sexuality discussions, but sexual comfort ($r = .31$) and sexual education and supervision experience ($r = .20$) did. Clinical experience was close to significance at $p = .08$.

Overall, sexuality education and supervision experience ($r = .37$) and sexual comfort ($r = .31$) had the greatest total direct and indirect effect on sexuality discussions, as compared to therapist perceived sexual knowledge ($r = .20$) and clinical experience
Certainly, therapists’ comfort levels in dealing with sexual issues will not increase with just clinical experience; clinicians must be supported and educated. In fact, because some clinical experiences can be unpleasant, perceived sexual knowledge may be a much more important factor in therapist comfort (Harris & Hays, 2008).

Harris and Hays (2008) failed to distinguish graduate-level supervision from postgraduate supervision when considering supervision experience. This is an important distinction, since the duration of supervisory support at the graduate level is of much shorter duration than at the postgraduate level, and therefore has less of an impact. In addition, Harris and Hays (2008) did not measure content validity or test-retest reliability and they used portions of the Sexual Knowledge and Attitude Test, a measurement that has low reliability (Fluharty, 1996). That they only used portions of a standardized instrument is also problematic. There are also generalizability issues with this study since Harris and Hays (2008) limited participants to clinical American Association of Marriage and Family Therapist (AAMFT) members. Lastly, Harris and Hays (2008) did not eliminate counselors specifically trained in sex therapy. Since sex therapists are expected to address sexual issues, their inclusion could have introduced bias. However, this is one of the few studies that examine willingness to discuss sexual issues, and it has ben through the publication process so it is fully vetted.

In the second study, Berman (1996) examined 301 social workers belonging to the National Association of Social Workers, in practice for at least one year in an outpatient mental health agency. The study sought to determine how a social worker’s formal and informal education, sexual comfort and agency support influence willingness
to address sexual issues with clients. Instruments included: (a) Agency support checklist authored by the researcher, (b) Education experience authored by the researcher, (c) Personal and general sexual comfort subscales of Sexual Comfort Instrument, and (d) Willingness to Discuss Clients Sexual Concerns subscale of the Client Sexual Concerns checklist. Although the effects were small ($\beta = .23, p < .01$), Berman (1996) found that informal sexuality education predicts comfort, whereas formal education did not. However, no relationship was found between agency support and willingness.

This was a valuable study because it distinguished between formal and informal education, and also considered agency support as a factor. However, there are reliability and generalizability issues with this study. Berman (1996) did not measure content validity or test-retest reliability, limited the sample to social workers, did not have adequate minority representation, and did not exclude sex therapists, possibly introducing bias. Lastly, the Berman (1996) study is a dissertation, not a published study, and therefore has not been vetted properly.

Another study found that sexual knowledge increases willingness rather than comfort in dealing with clients’ sexual concerns. Arnold (1980) examined counselors in training to investigate the relationship between willingness and comfort and the following: (a) completing a course in human sexuality, (b) affective arousal of counselor as sexual human being, and (c) counseling student sexual knowledge and experience. Participants were 68 students enrolled in graduate level counselor training programs at the University of Northern Colorado in Greenley, Colorado.
The instruments utilized were the: (a) Psychology Today Sex Survey to gather data on participant’s sexual attitudes, experience and demographics, (b) The Sex Knowledge and Attitudes Test (SKAT, Arnold, 1980) to assess sexual attitudes, knowledge and experience of helping professionals, and (c) the Client Sexual Concern Check List (CSCCL) constructed in 1979 by the researcher, as there was no such instrument to measure counselor willingness to deal with clients’ sexual concerns or counselor comfort. To get a list of common sexual concerns, the CSCCL item pool was created from research of technical publications, such as those by Masters and Johnson (1970), along with articles from lay magazines such as the Ann Landers column. For each item, there are two questions for the person taking the test: (a) “I would try to help the client deal with this concern,” and (b) “Working with such a client would be difficult.” A Likert scale was used to measure the responses (i.e., “strongly agree” to “strongly disagree”). The treatment group took the SKAT, followed by the Psychology Today Sex Survey (PTSS), then the CSCCL, whereas the control group took the CSCCL first, and then the other two. The rationale for this design was that taking the SKAT and the PTSS would create affective reaction, and the effects of this reaction could be measured by the CSCCL.

Treatment group subjects scored significantly lower on the comfort scale of the CSCCL, ($t(33) = 2.91, p < .01$). Therefore, neither educational level, counseling experience nor participation in a graduate level course in human sexuality insulated participants from this effect. No differences were found on the willingness scale ($t(33) = 1.92, p < .05$), indicating that counselors are willing to address these issues even when they do not feel comfortable. A significant positive correlation was found between the
knowledge scale of SKAT and the willingness scale \( r(66) = .31, p < .05 \), indicating that more knowledge makes counselors more willing. No relationship was found between completing a graduate human sexuality course and liberality of sexual attitudes.

One of the instruments in the Arnold (1980) study, the Client Sexual Concern Checklist, was not tested on any participants other than those in the study. In addition, the Arnold (1980) study is 32 years old, making the information in it somewhat outdated. Lastly, the Arnold (1980) study is a dissertation, not a published study, and as a result has not been properly vetted.

**Limitations.** Although the literature base commonly cites knowledge as a way to increase comfort with sexual topics, and therefore willingness to address such topics, there is confusion regarding the relationship of these variables, and little empirical data. In fact, Decker (2010) found no correlation between knowledge and comfort in her study of 103 clinical supervisors.

There were also methodological problems with the studies (Arnold, 1980; Berman, 1996; Decker, 2010; Harris & Hays, 2008; Weerakoon et al., 2008) in this section. Decker (2010) utilized an instrument without reliability measurements, Harris and Hays (2008) used an instrument with low reliability, and Arnold (1980) did not test the instrument prior to using it in the study. With regard to population, the Decker (2010) study was limited to marriage therapists from California, Harris and Hays (2008) was limited to marriage therapists, and Berman (1996) was limited to social workers. Lastly, Arnold (1980), Berman (1996), and Decker (2010) are unpublished dissertations, so they have not been thoroughly vetted.
In conclusion, although there was some variation on how knowledge, comfort and willingness are related, it is generally understood that increasing knowledge will be beneficial to therapists in that it will increase the likelihood that they will address clients’ sexual issues. The next subsections describe how the therapist variables of gender, specific sexual topics and religious fundamentalism affect willingness to discuss sexual issues.

**Gender**

There are contradictory results regarding the relationship between counselor gender and comfort level with sexual topics. Fluharty (1996) found male counselors less comfortable, Berman (1996) and Decker (2010) found no difference, Ford and Hendricks (2003), and Haag (2009) found male therapists more comfortable, and Papaharitou et al. (2008) found that male students in health-related fields, including psychology, were more sexually liberal than females. Cowden and Bradshaw (2007) found males had more concerns about performance, and stricter gender roles; whereas females had more sexual guilt and masturbation discomfort. The next two studies (Papaharitou et al., 2008; Fluharty, 1996) explore the role of gender as it applies to comfort with sexual topics.

Papaharitou et al. (2008) studied 714 students of health professions, including psychology, recruited from two universities in Greece and divided into subgroups according to their field of study. Instruments included one developed by the authors to assess general sexual information, such as age of first intercourse, and the source of sexual information for the participant, and the Derogatis Sexual Functioning Inventory to assess sexual attitudes.
Results indicated that male participants were more sexually liberal as compared to female participants ($t(712) = 5.397, p < .001$). Also, participants who got sexual information from friends, or learned sexual behavior from the media, or were considered less religious were more liberal; but participants who learned sexual information from their mother were less liberal.

Rather than measuring sexual comfort, knowledge or willingness to discuss sexual issues, Papaharitou et al., 2008 measured the more general concept of sexual attitude. Although it logically follows that a sexually liberal person will feel less discomfort, sexual comfort was not measured directly in this study. In addition, the participants were students, and did not include any licensed clinicians or clinicians practicing independently. The participants were also from Greece. Both of these factors reduce the generalizability of this study.

In the next study, Fluharty (1996) recruited 75 counseling and clinical psychologists from various settings to determine if therapist sexual training, therapist gender and client gender affect therapists’ anxiety when clients raise sexual issues. For a more cohesive sample, only counseling and clinical psychologists were included. Social workers, and marriage and family practitioners were not included. Therapists were placed into eight groups based on their level of training, including practicing psychologists ($n = 39$) and psychologists-in-training ($n = 36$), gender, and gender of client. Participants watched a video of a client, and were instructed to respond to the client as if they had seen them for two to three sessions. Their responses to the 30-second pauses in the tape were audio recorded and later transcribed for analysis.
Actors created the client films, with one script developed using the criteria of inhibited sexual desire. These scripts were validated by two sex therapists.

Instruments used were the Stroop Test (to measure the cognitive component of distress), behavior analysis of therapist (behavior classified as either approach, avoidance or neutral), the therapists’ State Anxiety section of the State-Trait Anxiety Inventory (administered directly following the videotape), and the Sex Knowledge portion of the Sex Knowledge and Attitude Test (Arnold, 1980). The Stroop test, which times word recognition when there is a discrepancy between word and color (i.e., the word “blue” written in red ink), was given pre and post stimulus (the videotape), with the difference score used in all statistics.

A MANOVA was used in a 2x2x2 design. Results showed a significant main effect only for the sex of the therapist, regardless of therapist level of training or client gender ($F(3, 61) = 2.87, p < .05$). The MANOVA also indicated that discomfort was not correlated with sex of client ($F(3,61) = 0.79, p = .27$), nor was there a difference in comfort when the gender of the client and therapist matched ($F(3,61) = .45, p = .72$). A significant interaction effect for gender was found in differences in self-perceived comfort between the two groups, practicing and in-training ($F(1,63) = 4.93, p < .05$), with practicing male therapists ($F(1,63) = 11.30, p < .05$), significantly more comfortable than those in training. Non-significant differences were found for female therapists.

Concerning how comfortable they felt with a female client versus a male client, more therapists felt comfortable with the female client ($F(1,63) = 7.34, p < .01$) as opposed to the male client.
There are several reliability and validity issues with this study. Fluharty (1996) used portions of the Sexual Knowledge and Attitude Test, a measurement that has low reliability. Further, Fluharty (1996) reported low power when comparisons were made between subgroups, and low inter-rater reliability including poor correlation between raters of avoidance responses. However, this study was unique in that it used an objective measure, the Stroop Test, to measure therapist anxiety as opposed to relying on self-report.

**Limitations.** There are contradictory results regarding the relationship between counselor gender and comfort level with sexual topics. Fluharty (1996) found male counselors less comfortable, Berman (1996) and Decker (2010) found no difference, Ford and Hendricks (2003), and Haag (2009) found male therapists more comfortable, and Papaharitou et al. (2008) found male students in health-related fields, including psychology, were more sexually liberal than females.

**Specific Sexual Topics**

Regarding counselor discomfort, the literature base does not appear to indicate that specific sexual topics can contribute to increased inhibition in counselors. Yet, because certain sexual topics are considered to be more sensitive, such as pedophilia, it follows logically that counselor discomfort may vary according to topic. Juergens et al. (2009) confirms discomfort with specific sexual topics, such as GLBT (Gay Lesbian Bisexual Transgender) or transgender clients as an area to research.

**GLBT.** GLBT issues are one possible problematic sexual topic for counselors. Although GLBT individuals seek counseling at a much higher rate, 50% as compared to 6% for hetero sexuals, there is a lack of research on both counseling GLBT clients, and
supervising GLBT counseling (Nystrom, 1997). There is also a general lack of training and exposure to serving GLBT sexual issues. Lastly, there is client perception of therapist homophobia, or heterosexism (Palma & Stanley, 2002).

**Transgender.** Rutter et al. (2010) studied the supervision and training aspects of two master’s level practicum students while counseling a GLBT couple in a marriage and family program in the Midwest. In this couple, one was a post-op transgender male (previously female) and the other was a lesbian. Although both of the counselors considered their work to be effective and reported that they were comfortable in addressing sexual issues, there was a general failure to address sexual topics. Specifically, the clients’ transgender status, the couples’ sexual relationship before surgery, and the sexual behaviors of the couples were problematic topics. Although the couple presented with “communication issues and a concern around their physical intimacy” and the supervisor prompted the counselor, the topic was not brought up for the first eight sessions. Both counselors reported their schools provided them with enough information, but only to counsel average clients, not clients with unique sexual circumstances, such as transgender status. Both counselors reported that supervision was helpful for processing their worries and fears, and nonjudgmental supervisors were especially helpful, but wished supervision had included role-plays on what to say.

Although generalization is not appropriate, since Rutter et al. (2010) was qualitative, this study served to highlight the concerns counselors may have in counseling sexual minorities. More specifically, it yielded specific information about the feelings and needs of counselors working with this population, such as the importance
Religious fundamentalism. As early as 1970, it has been thought that there may be a connection between religious fundamentalism and sexual problems, including guilt. Masters and Johnson (1970), considered leaders in the sex therapy movement, noticed a connection between religious orthodoxy and sexual dysfunction in the couples that they treated. More recently, several researchers think there is a positive link between religious fundamentalism and sexuality discomfort (Ahrold & Meston, 2010; Baier & Wampler, 2008; Barkan, 2006; Daniluk & Browne, 2008; Hull, 2008; Kwee & Hoover, 2008), including some who have found some empirical evidence (Cowden & Bradshaw, 2007; Gravel et al., 2011; Papaharitou et al., 2008; Schwartz & Lindley, 2009). In addition, one researcher, Haag (2009), found a significant negative correlation between religious fundamentalism and counselor self-efficacy concerning addressing the topic of sexually variant activities with clients. Four studies (Cowden & Bradshaw, 2007; Gravel et al., 2011; Haag, 2009; Schwartz & Lindley, 2009) relating to religiosity will be covered in this section.

Cowden and Bradshaw (2007) studied 365 college students to explore the relationship between religious orientation and sexual concerns. In addition to classifying the participants according to religious affiliation (Catholic, mainline Protestant, fundamentalist Protestant, Muslim, Jewish, other or none), the researchers also determined religious orientation based on motivation. Intrinsic religious orientation was defined as religion pursued for its own sake, extrinsic meant pursued for social or solace reasons, and quest meant the use of religion as a means of exploring deeper
existential questions, such as the meaning of life. Quest religious orientation is considered the opposite of religious fundamentalism (Cowden & Bradshaw, 2007). Instruments included the Religion as Quest scale, the I/E-R scale, and the Attitudes Related to Sexual Concerns (ASC) scale. The first two instruments measure religious orientation, and the ASC measures attitudes about sexual concerns, such as performance anxiety. The ASC is composed of subscales, with higher scores indicating negative outcomes, i.e., sexual guilt, masturbation concerns, and lack of sexual self-understanding (Cowden & Bradshaw, 2007).

Results indicated that intrinsic religious orientation, and to a lesser extent extrinsic religious orientation, were significantly related to high scores on the ASC (Intrinsic: $r = .27, p < .01$; Extrinsic: $r = .25, p < .001$), particularly the Guilt and Masturbation sub-scores (Guilt: $r = .54, p < .001$; Masturbation: $r = .44, p < .01$). Quest religious orientation, on the other hand, was negatively associated with the Guilt and Masturbation sub scores (Guilt: $r = -.15, p < .01$; Masturbation: $r = -.15, p < .01$) and positively associated with the sexual self-understanding sub score ($r = .14, p < .01$) (Cowden & Bradshaw, 2007). Thus, results indicated that those with intrinsic or extrinsic religious orientations were more likely to have sexual concerns as compared to those with a quest religious orientation.

Regarding religious affiliation, there was a significant positive relationship between ASC scores and specific religious affiliation ($F(5, 353) = 8.60, p < .001$), with the “other” having far less sexual concerns. More specifically, the “other” group reported much less guilt ($F(5, 352) = 14.34, p < .001$) than any other group with the
exception of the “no affiliation” group. Thus, results from this study suggest a positive relationship between religious fundamentalism and sexual concerns, including guilt.

There is much strength to this study. Cowden and Bradshaw (2007) use instruments with a good reliability record that have been used on similar populations. More specifically, the I/E-R had Cronbach’s scores of .85 for the intrinsic scale and .72 for the extrinsic scale. However, one weakness to this study is its generalizability due to an ethnically biased sample. Although Cowden and Bradshaw (2007) claim that the addition of a historically Black university ($n = 124$) to the sample increases its diversity, it causes the sample to become somewhat unbalanced (54% White, 27% Black) and therefore not representative of the U.S. population. Further, the percentages of Hispanic (.07) and Asian (.05) participants are relatively small. According to the U.S. Census Bureau (2008), the U.S. population is 78.1% White, 16.7% Hispanic, 13.1% Black, and 5% Asian. Thus, the Cowden and Bradshaw (2007) sample is not representative of the U.S. population. Another limiting factor is that all the participants were college students, with a mean age of 23.35 years for one university and 20.75 for the other. Students are less likely than therapists to have clinical experience or knowledge, thus further biasing the sample.

Gravel et al. (2011) studied 269 university students from two different ethnic groups in Canada, the Anglo-Canadians and the Franco-Québécois, to determine if parental permissiveness and religiosity mediated sexual guilt. Religiosity was assessed using the Strength of Religious Faith Questionnaire, and sexual guilt was assessed using the Attitudes Related to Sexual Concerns Scale. Results indicated that the model accounted for 23% ($F = (3, 265) = 28.03, p < .0001$) of the differences in sexual guilt
between the Anglo-Canadians and the Franco-Québécois. The paths linking parental sexual permissiveness \( (t = -2.99, p < .01) \) and religiosity \( (t = 6.25, p < .0001) \) to sexual guilt were significant, suggesting that both lower parental permissiveness and greater religiosity were associated with greater sexual guilt.

The Strength of Religious Faith Questionnaire used in the Gravel et al. (2011) study measured the “importance of faith in an individual’s daily life” (p. 134) but did not capture the defining elements of religious fundamentalism, the adherence to dogma, or the more subtle differences in religious motivation (Cowden & Bradshaw, 2007) that could affect sexual guilt. Because Cowden and Bradshaw (2007) measured religiosity in a different way, the conclusions from this study have more limited value. In addition, there could be other differences between the two ethnic groups not identified by the study that affect sexual guilt, since their model only explained 23% of the differences in sexual guilt. Lastly, the sample consisted of university students from Canada, so the results may not be generalizable to other demographic groups and the U.S.

Haag (2009) studied 115 psychotherapist trainees in various doctoral programs to determine what characteristics predict counselor self-efficacy (CSE) about addressing clients’ issues related to variant sexual behavior. Instruments included the Modified Sexual Practices Questionnaire (SPQ) to measure sexual values and comfort, the Personal Attributes Questionnaire, and the Religious Commitment Inventory. Results indicated lower levels of religiosity predicted CSE for sexual issues \( (\beta = -.31, p < .001) \).

No validity or reliability measurements were performed on the SPQ, and the sample size was relatively small to do a prediction in the Haag (2009) study. However,
this study is unique in that it links religiosity with counselor self-efficacy regarding discussing clients’ variant sexual practices. In addition, the sample was composed of doctoral students, who have less clinical experience than therapists.

Schwartz and Lindley (2009) studied 198 students at a mid-sized southern university to explore whether attachment mediated the relationship between religiosity and homophobia. Instruments included the Relationship Questionnaire to determine attachment style (Secure, Fearful, Preoccupied or Dismissing), the Adult Attachment Scale to measure the underlying dynamics of the attachment style, the Homophobia Scale to measure the cognitive, affective and behavioral components of homophobia, the Religious Fundamentalism Scale to measure religious fundamentalism, and the Marlowe-Crowne Social Desirability Scale to identify participants who tend to describe themselves in an overly positive way.

A hierarchical regression analysis was conducted to determine the factors that predict homophobia. Sex and social desirability were entered on the first step. Religious fundamentalism, anxiety and avoidance were entered on the second step. Out of these variables, only religious fundamentalism ($\beta = .44, p < .001$) contributed to the prediction of homophobia.

The intention of this study (Schwartz & Lindley, 2009) was to determine the role attachment plays in the relationship between religious fundamentalism and homophobia, not to predict the relationship between religious fundamentalism and homophobia. However, this is because the authors felt there was enough evidence to establish a positive relationship between religious fundamentalism and homophobia. Also, homophobia is just one element of sexual shame. Although, as stated previously,
a sense of shame about an aspect of sexuality is not only problematic in itself, but may lead to a more generalized sense of shame regarding sexuality.

Other limitations of this study involve the population. All participants were students, a population that is younger than the general population. Further, the participants were disproportionally Christian (91%) and Baptist (41%). The U.S. Census Bureau (2008) estimates the Christian population of the U.S. at 76%, with Baptists at 16%.

**Limitations.** Cowden and Bradshaw (2007), Gravel et al. (2011), Papaharitou et al. (2008), and Schwartz and Lindley (2009) studied general sexual attitudes, rather than willingness to engage in discussion of sexual issues. Cowden and Bradshaw (2007) studied sexual concerns, Gravel et al. (2011) studied sexual guilt, Papaharitou et al. (2008) studied sexual liberalism and Schwartz and Lindley (2009) studied homophobia. Further, the samples in all the studies (Cowden & Bradshaw, 2007; Gravel et al., 2011; Haag, 2009; Papaharitou et al., 2008; Schwartz & Lindley, 2009) were composed of students, a population that could be very different in maturity and life experience from therapists. Lastly, Haag's (2009) study was a dissertation, so the methods and conclusions have not been as thoroughly vetted as compared to a published article.

**Role of Clinical Supervisors**

Importance has been placed on the supervisory relationship as a unique place where counselors can work through their feelings of discomfort or shame about sexuality or about counseling clients with sexual issues (Heru, 2006; Ridley, 2006). Therefore, one way in which supervisors can help supervisees is by encouraging them
to explore their internal, subjective sexual views so that supervisees can help clients address theirs (Ridley, 2006). Supervisors should also assist supervisees in processing their sexual reactions to clients (Ridley, 2006). Negative feelings of disgust or shame are difficult to deal with, but positive bodily reactions such as sexual arousal can also be alarming in a professional setting (Ridley, 2006). However, for the same reasons that counselors can be uncomfortable with sexual topics, supervisors may be as well.

Yet, counseling supervisors are in a unique position to assist novice counselors in addressing their discomfort for two main reasons. First, due to a general lack of experience, it is more likely that a newly licensed counselor or intern will have more trouble with this topic than an experienced clinician. Because one of the main functions of the supervisory relationship is to help counselors manage uncomfortable feelings of counter-transference, it follows that helping them address their own internalized shame or embarrassment about sexuality would be on the supervisory agenda. Second, positive supervisory experiences play a larger role than clinical experience in helping counselors feel more comfortable with this topic (Harris & Hays, 2008; Hays, 2002).

**Education.** Many researchers have linked sexual knowledge to comfort with sexual topics (Berman, 1996; Harris & Hays, 2008; Juergens et al., 2009; Kazukauskas & Lam, 2010; Papaharitou et al., 2008; Post et al., 2008; Simpson et al., 2006; Weerakoon et al., 2008), and, more specifically, to the likelihood of initiating sexual discussions with clients (Berman, 1996; Harris & Hays, 2008; Juergens et al., 2009; Papaharitou et al., 2008; Weerakoon et al., 2008). Therefore, another way to assist supervisees is by educating them.
Because supervisory experience is more important than clinical experience to increase comfort (Harris & Hays, 2008), and informal sexuality education is more important than formal education (Berman, 1996) in increasing counselor willingness, supervisors are in a unique position to assist counselors. For example, supervisors can help educate by including a vignette of sexual issues and an accompanying role-play with a supervisor (Rutter et al., 2010).

Not all of the researchers appear to be in agreement. For example, Fluharty (1996) found no correlation between training level or sexual knowledge, and comfort level in counselors. In addition, Arnold (1980) found that knowledge significantly increases willingness, not comfort, in counselors so perhaps therapist comfort is less important than previously postulated. Lastly, the Berman (1996) finding that agency support did not increase counselor willingness to address sexual issues may mean that supervisory support may not be that important, since supervisory support can be considered to be similar to agency support.

**Anxiety.** Sexual knowledge will not increase sexuality discussions if there is counselor anxiety (Harris & Hays, 2008). Besides being knowledgeable, therapists must be able to “sit with the anxiety” (Harris & Hays, 2008, p. 248). Therefore, supervisors must not only educate supervisees on sexuality, they must also be prepared to assist them with handling anxiety. Since this is a natural role of supervision, it logically follows that supervisors are in the best position to assist counselors in this way.

**Boundaries.** Another way supervisors can help supervisees is by instructing them on appropriate topics for supervision and how topics are initiated. There are two
reasons for this. First, there is an inherent power differential in the supervisory relationship. Just as clients perceive counselors as the experts, and therefore may be reluctant to raise sensitive topics such as sexuality, counselors may be reluctant to raise this topic with their supervisors (Harris & Hays, 2008).

Second, besides their own internalized sexual shame, supervisees may be disinclined to bring up sexual concerns because they correctly (Morgan & Porter, 1999) or incorrectly (Heru et al., 2004; Hartl et al., 2007) project their own discomfort onto their supervisors. By opening up the dialogue in supervision, supervisors can inform supervisees of the clinical importance of such discussions, an important step toward eliminating supervisee discomfort.

Establishing and maintaining appropriate boundaries in supervision is also an essential ingredient in establishing trust (Hartl, et al., 2007; Heru, 2006; Heru et al., 2004). Heru et al. (2004) studied 43 supervisors and 52 supervisees in the Brown University Department of Psychiatry and Human Behavior. Participants were given a 19-item questionnaire asking about the appropriateness of the actions of a psychotherapy supervisor. A MANOVA was conducted to detect differences between supervisors and supervisees. Results indicated that supervisors and trainees agreed on most items. However, supervisors, more so than supervisees ($F = 5.14$, $df = 1,92$, $p = .03$), generally consider sexual subjects appropriate for supervision (Heru et al., 2004).

Limitations of this study include possible issues with generalizability. The majority ($n = 39; 91\%$) of the supervisors were psychiatrists, and it is unknown if they have training or experience in psychotherapy. Supervisors in mental health counseling,
marriage and family therapy, and social work were excluded. There is also a possible issue with the demographics of the overall sample. Although Heru et al. (2004) report that their sample is biased because it consists primarily of Caucasians, the authors did not include demographic information and therefore this cannot be confirmed.

Although very little is known about the optimum supervisory relationship (Heru, 2006; Heru et al., 2004), supervisors need to welcome and encourage discussions about sexual issues to establish safety. Further, although clinicians may be uncomfortable because they have negative internalized views of sexuality, or are embarrassed by their own reactions (Ridley, 2006), they will generally not bring up these topics in supervision because they fear an adversarial reaction from the supervisor (Hartl et al., 2007). Specifically, supervisees may be reluctant because they: (a) are unsure of clinical relevancy, (b) expect judgment or negative response from the supervisor, (c) think their strong reactions, especially shame, are unprofessional, (d) think the supervisor will be uncomfortable with discussing sexual issues, or (e) have inherent difficulty with discussing subjective issues (Hartl et al., 2007).

Therefore, it follows that supervisors play an important role in initiating these types of discussions. Going further, it is important for supervisors to understand how to facilitate discussions about sexual issues, because the topics that usually need the most attention are the topics that counselors avoid discussing with their supervisors (Heru et al., 2004). However, before supervisors initiate the topic, they must develop a good working alliance with their supervisees (Harris & Hays, 2008).

**Alliance.** Creating and maintaining an effective supervisory relationship is of vital importance in promoting openness about sexuality because it helps to increase
supervisees’ comfort (Harris & Hays, 2008). Namely, in order for supervisees to discuss sexual concerns with their supervisors, they must have some reassurance that they will not be judged negatively (Hartl et al., 2007) or laughed at (Morgan & Porter, 1999). A safe, open relationship is necessary (Decker, 2010) to reduce this fear and anxiety in the supervisee. It is also important that the supervisor be comfortable with sexual topics (Decker, 2010). Establishing an alliance with the supervisee and properly managing interpersonal conflicts are central to creating this effective relationship (Heru, 2006).

Critical Evaluation of Current Literature

Religious fundamentalism. Although many researchers have described a connection between religious fundamentalism and sexual shame (Ahrold & Meston, 2010; Baier & Wampler, 2008; Barkan, 2006; Cowden & Bradshaw, 2007; Daniluk & Browne, 2008; Gravel et al., 2011; Haag, 2009; Hull, 2008; Kwee & Hoover, 2008; Schwartz & Lindley, 2009), only a subset have reported empirical data (Cowden & Bradshaw, 2007; Gravel et al., 2011; Haag, 2009; Schwartz & Lindley, 2009). Except for Haag (2009), although these studies have provided empirical data, they measure therapist sexual attitudes rather than therapist willingness or therapist comfort. Although sexual attitudes can certainly affect therapist willingness or comfort, there are many more factors that can contribute.

There are also problems regarding generalizability. Cowden and Bradshaw (2007) had a disproportionally Black sample, and Schwartz and Lindley (2009) had a disproportionally Christian and Baptist sample. Lastly, another limiting factor is that all the participants were college students.
Counselor willingness. Empirical data on increasing counselor willingness to discuss sexual issues with clients is sparse. There were only two studies (Berman, 1996; Harris & Hays, 2008) out of the main studies that measured counselor willingness as a dependent variable. Berman (1996) reported that the instrument used to measure willingness was not reliable. Although this does not completely negate her results regarding this variable, it does place them into question. Since Berman (1996) did not find a correlation between agency support and willingness, it is unknown if there was no relationship, or if there was one and the instrument failed to detect it. That leaves one study (Harris & Hays, 2008) that measured counselor willingness in a reliable manner.

However, Harris and Hays (2008) failed to distinguish graduate-level supervision from postgraduate supervision of counselors. This is an important distinction, since the duration of supervisory support at the graduate level is of much shorter duration than at the postgraduate level, and therefore could have less of an impact. Further, postgraduate practitioners are more experienced, further increasing the power differential between counselor and client, and therefore the client may have greater expectations that the counselor will address their sexual issues.

The remainder of the main studies (Decker 2010; Fluharty, 1996; Haag, 2009) explored which factors contributed to therapist comfort, which isn’t the same construct as willingness. Further, out of the five main studies, four are dissertations rather than articles published in peer-reviewed journals. Harris and Hays (2008) is the only published article.

Counselor comfort. There have been several studies (Arnold, 1980; Berman, 1996; Decker, 2010; Ford & Hendrick, 2003; Haag, 2009; Harris & Hays, 2008;
Weerakoon et al., 2008) on how to increase counselor comfort with sexual topics, including the role of knowledge. However, only two studies (Berman, 1996; Harris & Hays, 2008) explored how comfort and knowledge increase willingness. Although a plausible hypothesis is that counselors who are more comfortable with the topic are more likely to address it, this may not necessarily be true. Even counselors who are comfortable with the topic may fail to address it for other reasons.

Reliability and validity. For the most part, reliability and validity measures are either unknown or poor for the five main studies. Each study had at least one instrument that was created by the author, and none were thoroughly tested. More specifically, Harris and Hays (2008) and Berman (1996) did not measure content validity or test-retest reliability, and Haag (2009) did not do any validity or reliability measures at all. In addition, two studies (Fluharty, 1996; Harris & Hays, 2008) used portions of the Sexual Knowledge and Attitude Test, a measurement that has low reliability (Fluharty, 1996). Lastly, Fluharty (1996) reported low power when comparisons were made between subgroups, and low inter-rater reliability, including poor correlation between raters of avoidance responses.

Professional identity. Both studies that measured willingness (Berman, 1996; Harris & Hays, 2008) have generalizability issues. Specifically, Harris and Hays (2008) limited participants to clinical American Association of Marriage and Family Therapist (AAMFT) members, and Berman (1996) limited participants to clinical social workers in an outpatient agency. Although it was not reported, it is likely that AAMFT members are primarily marriage and family therapists, or other mental health professionals who commonly work with couples and families. Thus, mental health, psychologists,
rehabilitation counselors and addictions professionals were not represented in either study. Going further, since marriage therapists are more likely to face sexual issues as an inherent factor in treating couples, they are more likely to have experience in this area, thus further biasing the sample in the Harris and Hays (2008) study. Berman’s (1996) sample was limited even further by eliminating social workers in private practice.

Regarding the other three main studies, those samples were biased as well. Fluharty (1996) limited participants to psychologists, Haag (2009) limited them to doctoral interns, and Decker (2010) limited them to members of the California Association for Marriage and Family Therapists. Thus, Fluharty (1996) eliminated marriage and family, mental health, social work, rehabilitation and addictions practitioners; Haag (2009) eliminated master’s level and experienced practitioners; and Decker (2010) eliminated psychologists, mental health, social work, rehabilitation and addictions practitioners.

Lastly, except for Decker (2010), none of the studies eliminated counselors specifically trained in sex therapy. Because it follows logically that counselors specifically trained in sex therapy will be willing to address sexual issues, these counselors should be eliminated, as their presence could confound the results. Going further, Decker (2010) only eliminated American Association of Sex Counselors Educators Counselors and Therapists (AASECT) certified therapists; therefore therapists trained in other sex therapy programs could have been included.

**Ethnicity and culture.** Ethnic breakdown was not reported in the Harris and Hays (2008) study, so generalizability about ethnicity is unknown. In the Berman (1996) study, 92.4% of participants were white non-Hispanic, a figure that is not representative
of the current ethnicity proportions in the United States. According to the U.S. Census Bureau (2008), the U.S. population is 78.1% White, 16.7% Hispanic, 13.1% Black, 5% Asian, 1.2% American Indian and Alaska Native, and .2% Native Hawaiian and other Pacific Islander. Berman (1996) explains that when the study was conducted there were not many minority social workers; however, this has changed, placing the ability to generalize ethnically from this study into question. Although Fluharty (1996) does not provide an ethnic breakdown of the participants, it is also likely to exclude ethnic minorities because the study was conducted in the same timeframe as the Berman (1996) study. Lastly, the Decker (2010) participants were all from California, a state known for its more liberal sexual attitudes, which could have confounded the results.

**Other sources of bias.** All five main studies, except for the Fluharty (1996) study, used self-report as a means of measuring comfort and willingness. Because counselors are expected to be open-minded and nonjudgmental, this could have biased the results due to the expectation that they would be comfortable with discussing any client issue. Although this risk is small, and considered to be an acceptable way of gathering data, it is worth mentioning that Fluharty (1996) did not rely on this method. Fluharty (1996) used the Stroop Test to measure the cognitive component of their distress, with a behavior analysis of the therapist to determine comfort levels. These are more objective measures and therefore are more accurate. However, this study measured therapist anxiety levels, and not willingness.

None of the five main studies compared subjective to objective measures of comfort and willingness. Although Fluharty (1996) used objective measures of anxiety and discomfort, subjective measurements were not taken, so it is unknown if the
objective measure of therapist discomfort would have matched the subjective measure. The remainder of the main studies did not use objective measurements of discomfort.

Another possible source of bias is that all the main studies, with Berman (1996) as the exception, used an online survey to gather data. Technology-adverse participants, or participants without access to the Internet, may have been eliminated.

**Summary**

Sexual issues are common: however, they often go unaddressed because of counselor discomfort. This can have deleterious effects on clients. Although correlates of counselor comfort have been studied, some of the findings conflict with each other. In addition, no study has explored the role that type of sexual issue may play in comfort. Furthermore, little is known about correlates of counselor willingness to initiate sexual topics, particularly in the supervisory context. More specifically, most researchers agree that a lack of knowledge, lack of experience and discomfort with sexual topics are all causes of counselor discomfort. However, only a few studies have tied this discomfort directly to unwillingness, and none have studied how supervisors can be of assistance. Lastly, previous research was conducted on marriage and family therapists (Decker, 2010; Harris & Hays, 2008; Hays, 2002), social workers (Berman, 1996) and psychologists (Fluharty, 1996). Including mental health counselors in the sample will add to the knowledge base, yield results that are more generalizable, and enable comparisons to be made using professional identity as the criterion.

Although supervisors are in a unique position to assist counselors in addressing their sexual discomfort and lack of knowledge, there is a dearth of research in this critical area. Some researchers have speculated on how supervisors can be helpful,
including suggestions such as establishing an alliance (Harris & Hays, 2008; Heru, 2006), providing sexual education (Harris & Hays, 2008; Juergens et al., 2009; Papaharitou et al., 2008; Post et al., 2008; Simpson et al., 2006; Weerakoon et al., 2008), and establishing boundaries (Hartl, et al., 2007; Heru, 2006; Heru et al., 2004).

Yet, there are no empirical data:

Presently, there have been no studies conducted investigating the influence of clinical supervision on therapists’ initiating sexuality-related discussions. With supervision being the second highest predictor of sexuality discussions in this study, it seems imperative that more research be conducted in this area. (Harris & Hayes, 2008, p. 249)

A recent search for “sexual issues” and “sexuality discussions” in the primary journal for counseling supervisors, *Counselor Education and Supervision*, since September 1961 (the original volume) yielded 237 and 42 results, respectively. None were found on the topic of discussing sexual issues during supervision, except for those covering specific multicultural issues such as GLBT clients.

This study would help to bridge these gaps by:

1) Providing more empirical data on correlates of counselor willingness and comfort;

2) Including mental health counselors in the sample; and

3) Enquiring about the supervisory experience from the counselor's perspective, including how supervisors can be supportive.

Chapter 3 will discuss the research methods used to conduct this study.
Chapter 3:
Design and Methodology

In Chapter 3, a reintroduction to the topic, as well as the research questions and research design will be presented. A discussion of the logic, structure and the design of the study will be provided, as well as threats to validity. Then, a description of the sample followed by a description of the instruments and data collection procedures will be presented. Lastly, the analysis plan will be provided.

Because sexual issues are common in the general population, it follows they will also be common among persons seeking counseling services. Despite the great need, the literature suggests that most counselors are often not prepared to discuss clients’ sexual issues, and as a result clients may not have their sexual issues addressed. This can result in a decrease in clients’ well being. In addition, preliminary research suggests that clinical supervision is an optimal process to prepare counselors for this task. The purpose of this study is to explore the experience of clinicians addressing clients’ sexual issues in the context of the counseling relationship, as well as in the supervisory relationship. Based on a review of the literature, three research questions have been identified.

**Research Questions**

1. What are counselor perceptions regarding how they address their clients’ sexual issues?
2. What is the relationship between counselor comfort with clients’ sexual issues and the following: counselor frequency of initiating sexual discussions, counselor professional identity, counselor gender, and counselor religious fundamentalism?

3. What are counselor perceptions regarding supervisory support in addressing sexual issues with their clients?

Research Hypotheses

H₀: Most counselors do not feel uncomfortable addressing their clients’ sexual issues.

H₁: Most counselors feel uncomfortable addressing their clients’ sexual issues.

H₀: No relationship exists between counselor comfort with clients’ sexual issues and the following: counselor frequency of initiating sexual discussions, counselor professional identity of sex therapist, counselor gender of female, and religious fundamentalism.

H₂: There will be a positive relationship between counselor comfort with clients’ sexual issues and the following: counselor frequency of initiating sexual discussions, counselor professional identity of sex therapist, and counselor gender of female; and a negative relationship between counselor comfort with clients’ sexual issues and religious fundamentalism.

H₀: Counselors do not feel unsupported by their supervisors in addressing clients’ sexual issues.

H₃: Counselors feel unsupported by their supervisors in addressing clients’ sexual issues.
Research Design

Because the research questions solicit both quantitative and qualitative data, a mixed methods approach, using both structured and semi-structured questions, was used for this study. In many cases, enough information was known about the topic by the author to formulate a structured question. In other cases, it was necessary to add an open-ended option, making the question semi-structured rather than structured. Since the open-ended option elicited a very specific and brief answer, the question was considered semi-structured rather than exploratory.

More specifically, a triangulation design was used to obtain different but complimentary data on the same topic (Creswell & Plano Clark, 2007). In this way, both the strengths of quantitative methods (large sample size, generalizations) were combined with the strengths of qualitative methods (more detail, in-depth information). With this design, the quantitative and qualitative pieces were collected and analyzed simultaneously, but separately. Then, the data sets were merged (Creswell & Plano Clark, 2007). Triangulation approaches, such as these, yield richer data because they use different types of data (Luyt, 2011).

Data analysis plan. Data were retrieved from the Survey Monkey online tool. It is used to collect and minimally analyze the quantitative data. Descriptive statistics were used to answer Research Question 1 and 3. Qualitative methods were used to answer Research Questions 1 and 3. SAS was used to calculate chi-square test of independence values to answer Research Question 2. A chi-square test of independence was chosen due to the categorical nature of the dependent variables, level of comfort with sexual issues and frequency of initiation of sexual issues (Grimm,
Percentages for each answer were calculated and analyzed to draw conclusions and identify trends. Results from the demographic questions regarding professional identity (Question Number two), gender (Question Number three), religious affiliation (Question Number five), and level of religious fundamentalism (Question Number six) were compared with results from Question Number seven, which asked, “How comfortable are you with addressing clients’ sexual issues?” to determine if reported comfort level varies with professional identity, gender, religious affiliation or level of religious fundamentalism. The same demographic results (professional identity, gender, religious affiliation and level of religious fundamentalism) were compared with results from Question Numbers eight, which asked, “Considering your caseload of individual clients as a whole, what percentage of the time have you initiated a conversation about sexual issues?” and nine, which asked, “Considering your caseload of couples clients as a whole, what percentage of the time have you initiated a conversation about sexual issues?” to determine if frequency of initiation of the topic of sexual issues varies with professional identity, gender, religious affiliation or level of religious fundamentalism. The results from Question Numbers seven, eight and nine were then compared to see if reported level of comfort corresponds to frequency of initiation of topic.

Some topics cannot be measured in a purely quantitative fashion. In some cases (i.e., discomfort with specific sexual topics) not enough information was known about the sub topic to formulate a closed question. Therefore, an open-ended option was required. In this case, the qualitative (semi-structured) portion of the question served to expand the number of options to the quantitative (structured) question. In these cases,
a data transformation model (Creswell & Plano Clark, 2007) was used. As with any other mixed method model, the data was collected and analyzed separately. However, in this sub-model, once the qualitative data were analyzed they were transformed into quantitative form. Then, all data was analyzed together in a quantitative fashion. For example, answers to the "other" option of the question “What do you do when a client raises a sexual issue about which you are familiar?” would be analyzed, categorized, and counted quantitatively. These quantitative results would then be combined with the quantitative results from the rest of the answers.

In other cases, the qualitative questions served to expand upon and validate the quantitative questions. In some cases, although enough information was known to formulate a quantitative question, that information was not complete. For example, some of the reasons that counselors avoid discussing sexual issues were known, but not the mechanics behind them. In these cases, the validating quantitative data model was used. Both the quantitative and qualitative data were analyzed separately, and then the qualitative results were used to expand upon and validate the quantitative results. This method allows for the embellishment of quantitative data, including quotes (Creswell & Plano Clark, 2007).

Content analysis was used to solidify the qualitative responses into categories and themes to make inferences (Stemler, 2001). Because the open-ended answers cannot be predicted, an inductive approach was required to identify themes (Bernard & Ryan, 2010). More specifically, emergent rather than a priori coding was used. After reviewing the data, unique and mutually exclusive categories were established by identifying features of the data (Stemler, 2001).
The data was reviewed using referential units (Stemler, 2001). Participants used slightly different terms to describe the same opinion or value, so it was important to consider common reference points when creating categories or themes. Lastly, referential coding is beneficial for making inferences about values (Stemler, 2001).

Once specific categories or themes were identified, codes were created to represent each theme. In content analysis, the text was tagged with predefined codes, and then analyzed quantitatively. The predefined codes were obtained by using the pre-defined answers in the survey. For example, for demographic Question Number 5, “I consider my religious affiliation to be _____,” the pre-defined codes would be “Catholic,” “Protestant,” and “Jewish.” When necessary, additional categories or themes were identified and added, and any data that had been previously coded was re-coded. For example, for demographic Question Number 5, codes were created for any additional categories represented by answers to the “Other” option. Once the codes were established, frequency counts were used to analyze the data quantitatively. Then, together with the responses from the closed-ended questions, patterns in the data were considered to form possible additional conclusions (Bernard & Ryan, 2010).

Inter-rater reliability. Inter-rater reliability is important when there may be subtle differences in the data (AERA, APA & NCME, 1999). Because this instrument elicited short-answer responses that had minimal subtle differences, Cohen's kappa was computed on ten percent of the open-ended questions that contained more than 3 responses (n = 10). A graduate student familiar with qualitative methods and knowledgeable about the survey was chosen as the other rater. Kappa was computed
on Question five, a demographic question regarding religious affiliation, to be .97, which is considered almost perfect (Bernard & Ryan, 2010).

Participants

Local mental health professionals were asked to participate in this study. As a convenience the sample was limited to the local Tampa Bay area of Florida. The author has been a practicing therapist in the area for the past 5 years, and knows several therapists in the area, including the president of the Tampa Bay Association of Marriage and Family Therapists. Because of these connections, it was thought that local participation would be greater as compared to participation in a part of the country with which the author was unfamiliar.

Professional organizations. One large local organization for mental health professionals, Suncoast Mental Health Counseling Association (SMHCA), has a public online directory (http://www.suncoastmhca.org/dr/sites/default/files/u2/DirectoryMay2012.pdf). A link to the survey was emailed to all 154 members on this list. The local organization for marriage and family therapists, the Tampa Bay Association of Marriage and Family Therapists (TBAMFT) did not have an online directory; therefore the president was contacted and agreed to email a link to the survey to all the members. The president of TBAMFT reported there are 175 members, but because their mailing list is longer, the president was unable to provide a definitive count.

On-line search. To increase generalizability and external validity, a third source of local counselors was used. Apart from personal recommendations, Internet searching is the most popular way of finding mental health professionals (Lipscomb,
Root, & Shelley, 2004). Therefore, additional emails were obtained by duplicating the online searches potential clients would be likely to use to find a therapist.

The Google and Yahoo search engines were used. Search terms included “Tampa Bay mental health counselor,” “St Petersburg mental health counselor,” “Clearwater mental health counselor,” “Tampa Bay licensed clinical social worker,” “St Petersburg licensed clinical social worker,” “Clearwater licensed clinical social worker,” “Tampa Bay marriage therapist,” “St Petersburg marriage therapist,” “Clearwater marriage therapist,” “Tampa Bay therapist,” “St Petersburg therapist,” “Clearwater therapist,” “Tampa Bay sex therapist,” “St Petersburg sex therapist,” “Clearwater sex therapist.” The sponsored search results were eliminated because in order to obtain contact information the link to that name must be selected at financial cost to the owner. The search results were then examined for links that specified licensed or registered mental health professionals, marriage and family therapists, social workers and psychologists. Exclusion criteria included therapists who had participated in the cognitive interviewing process and those who did not provide either an email address or a contact form. Of those links, if the website provided an email address, it was used. If the website had a contact form, it was filled out with the content indicated in Appendix B.

If the person responded with their email address, it was added to the list, and the person was sent an email expressing appreciation for their potential participation. All email addresses were added to an Excel spreadsheet and sorted to eliminate duplicates. The person’s name was also added to a list to avoid sending duplicate email messages. This resulted in an additional 104 email addresses.
**Total potential participants.** The on-line list was then merged with the SMHCA list, and duplicates were eliminated, resulting in 239 potential study participants. This combined list, when added to the approximately 175 members of the TBAMFT list, formed a combined list of 424 potential participants.

According to Kaplowitz, Hadlock, and Levine (2004), a response rate of 30% is typical for online surveys. However, researchers with similar surveys actually had higher rates of return. Hays (2002) reported a response rate of 53% and Berman (1996) reported 70%. Therefore, a conservative estimate of the response rate would be 40%, or 166 participants.

**Power.** An a priori power analysis indicated that 85 participants are required to have 80% power for detecting a medium sized effect (.15) when employing the traditional .05 criterion of statistical significance (Faul, Erdfelder, Buchner, & Lang, 2009; Faul, Erdfelder, Lang, & Buchner, 2007). According to Cohen (1988), Cohen (1977), and Stevens (2007), 80% power is considered desirable for determining differences in data in behavioral research. Therefore, sufficient participation was projected. However, a post hoc analysis of the data revealed that the originally planned statistical method of regression was not appropriate due to the categorical nature of the dependent variable and the decision was made to calculate chi-square test of independence instead (Grimm, 1993). Therefore, Cramer’s V (Cramér, 1946) was calculated to determine effect size. Cramer’s V is a measurement of association for categorical variables, and allows for different sample sizes and different numbers of cells. It is related to the phi-coefficient and the Pearson contingency coefficient, which
are also based on the chi square statistic, but are much more limited with regard to application (Everitt & Skrondal, 2010; Vogt, 1999).

Instrument

Because no pre-existing instrument was found that explores reasons (including specific sexual topics) for counselor sexual discomfort and unwillingness to address sexual issues, or the specific actions counselors take when a client raises a sexual issue, or that measures ways in which supervisors can assist, the author developed a survey based upon the results of a literature search, her clinical knowledge as a sex therapist, and the results of one unpublished study (LoFrisco & Hicks, 2012).

LoFrisco and Hicks (2012) interviewed eight counseling supervisors from a large city in a southeastern state to explore how counselors and supervisors define sexual issues, how comfortable counselors and supervisors are with clients’ sexual issues, and how counseling supervisors support their supervisees in addressing clients’ sexual issues. The interviews were conducted individually using a semi-structured format. Results from these interviews, including types of sexual topics that may cause discomfort to therapists, were included in the development of this survey.

The survey is divided into three sections (See Appendix C). Section 1 includes six demographic questions. Section 2 includes 18 questions about current practice. Section 3 includes five questions about experiences in supervision. Thus, the survey has a total of 29 questions.

Demographic questions. Section 1 elicited demographic information from the participants. Questions include type of licensure, whether the participant is currently practicing psychotherapy, gender, ethnicity, and religious beliefs. Persons no longer in
practice were eliminated to increase the accuracy of the results, thus increasing internal validity. In addition, this section elicited the information necessary to partially answer Research Question 2.

**Current practice questions.** The next section addresses current practice, including participants’ experience working with clients’ sexual issues. These questions focus on the reasons participants may be unwilling to address sexual issues. They include questions about comfort and frequency. These questions were designed using information obtained from the results of a literature search, the author’s clinical knowledge as a sex therapist, and the results of one unpublished study (LoFrisco & Hicks, 2012). These questions were validated via review by two experts and a cognitive interviewing process. Thus, this section answers Research Question 1. Please refer to Appendix D, which describes the flow of questions graphically.

**Postgraduate supervisory experiences.** The next section explores how the participant’s supervisor supported them in addressing clients’ sexual issues. Options for support include instruction on appropriate topics, providing educational materials, discussing the counselor’s comfort level, helping the counselor to process own discomfort, and exploring the role religion plays. These options are based on the work of Harris and Hays (2008) regarding sources of counselor discomfort, and the consensus in the literature regarding the possible connection between religious fundamentalism and sexuality (Ahrold & Meston, 2010; Baier & Wampler, 2008; Barkan, 2006; Daniluk & Browne, 2008; Hull, 2008; Kwee & Hoover, 2008), and the results from the LoFrisco and Hicks (2012) interviews. These questions were validated via review by two experts and a cognitive interviewing process. Participants who have not had
clinical supervision in the past 10 years were eliminated to increase accuracy of the results, thus increasing internal validity.

**Internal consistency.** Although participants were considered to be generally similar, because there are so many branching off points in the survey, the participants did not answer the same set of questions. Therefore, it was decided to wait until after data collection to compute Cronbach’s alpha (Crocker & Algina, 2006). However, upon further review of the study questions it was decided not to add any additional questions to the survey, which would have been a requirement for in order to properly use Cronbach’s alpha. Because this study is explorative, the survey is designed to cover many different constructs, as opposed to measuring just a few. Since Cronbach’s alpha is based on the premise of homogeneity (Tavakol & Dennick, 2011), it is not an appropriate measurement for this type of survey.

**Content validity.** Two practicing sex therapists other than the author were given the survey for initial review. The first sex therapist has seven years of Postgraduate experience as a sexologist. The second sex therapist has nine years of experience working with sexual issues, and was granted the formal title “sex therapist” in May of 2012. Both attended the American Academy of Clinical Sexologists doctoral program for their sexology training and are currently in private practice. After giving them a brief explanation of the purpose of the survey, both counselors were asked to ensure major content areas were covered.

The comments from the first counselor were almost entirely positive. The first counselor did suggest adding a question to ascertain whether clinicians know when to refer to a sex therapist. Because this could affect a counselor’s comfort level in
referring clients, it was added to the survey. The comments from the second counselor were also almost entirely positive, and included a suggestion of changing a rank question to a Likert scale item. This adjustment was made. Beyond that, both individuals reported the items in the instrument were relevant and important, thus confirming the survey has construct validity (Onwuegbuzie, Bustamante, & Nelson, 2010).

Along with checking for completeness of domain, these two experts also examined the questions to see if they were worded properly and made sense. The response was mostly positive. Suggestions included a few grammatical and term changes, which were made.

**Cognitive interviewing.** Cognitive interviewing focuses on the cognitive process of the participant as they are completing a survey. Unlike other forms of content analysis, such as expert review, this method allows the researcher to understand the participant’s thinking process, rather than relying on their final perception. Two participants have been selected for the cognitive interviewing process. One is a female Registered Mental Health Counseling Intern (RMHCI) and the other is a female licensed mental health counselor (LMHC) with six years of experience as a licensed counselor.

Because the questions in this survey are of such a sensitive nature, understanding how participants process the questions is important. Once the cognitive processes are understood, then the wording or content of the questions can be modified according to what was learned. The cognitive interviewing process seeks to understand four general categories of normally covert processes (Willis, Casper, & Lessler, 1999):
- Comprehension of the question. Does the participant understand the question, including any terms used?
- Retrieval from memory. How well does the participant remember the information? Was it difficult for them to recall?
- Decision processes. Does the participant put forth the required effort to answer the question accurately and thoughtfully? How does the participant feel about answering the question?
- Response mapping. How well can the participant map the given choices to their internal thinking? Do the choices make sense to the participant?

There are two types of cognitive interviewing, think-aloud and verbal probing. Think-aloud interviewing, where the participant details their cognitive processes orally to the researcher, places too much burden on the participant, including extensive training (Willis et al., 1999). Verbal probing, on the other hand, relies on the researcher to ask the participant specific questions. With verbal probing, control remains with the interviewer, eliminating extraneous discourse, and there is little or no training of the participant. For these reasons, verbal probing was used for this study. The participants were, however, encouraged to share any thoughts or thinking processes aloud as a supplement to the verbal prompts. One possible issue, however, with verbal probing is the potential to influence the participant to answer in a particular way by suggesting specific alternatives. Therefore, to help prevent bias, the questions were worded in such a way as to not lead the participant in a particular direction (Willis et al., 1999). For example, Question Number 8 asks, "Considering your caseload of individual clients
as a whole, what percentage of the time have you initiated a conversation about sexual issues?” rather than, “Do you ever ask your clients about sexual issues?”

There are also two general approaches to probing: concurrent or retrospective. With concurrent probing, questions are asked as the participant is participating in the survey. With retrospective probing, questions are asked after the participant has completed the survey, and is considered a debriefing session. However, retrospective probing relies on memory, and by the time the participant has reached the end of the survey he or she may have forgotten what their cognitive processes were. Concurrent probing is more frequently used for this reason (Willis et al., 1999), and was used in this study.

Lastly, probes can be either scripted or spontaneous (Willis et al., 1999). For consistency, and to help ensure thoroughness, scripted probes were used. However, probes were added spontaneously when needed, such as when the participant hesitated or appeared uncomfortable, or when more follow-up was needed. The scripted verbal probes, along with the original version of the survey, are provided in Appendix E.

**Cognitive interviews.** The interview was conducted with the RMCI first. Considering the feedback, a few items were changed in the survey. To avoid re-interviewing, these items were changed before interviewing the second participant. Except for Question Numbers 13 through 19, which lists specific sexual issues and asks participants to select all that make them feel uncomfortable, which made the RMHCI feel “avoidant” and “yuck,” there were no negative reactions or feelings to any of the questions. However, considering the comments, there were some content changes.
Specifically, Question Number 10 was modified to specify sexual issues “beyond the participant’s comfort level,” rather than just “sexual issues.” Question Number 11, which asks where the individual would refer a client with sexual issues, was changed to allow for multiple answers. Question Number 12 was changed from “How do you determine when to refer clients?” to “How do you determine when sexual issues are beyond your comfort level?” The skip logic was modified so that participants did not skip Question Numbers 13 – 18. The question “I feel embarrassed by clients’ sexual issues? T/F” and “Why?” were removed because they were redundant. A Question was added after Question Number seven to distinguish between individual and couples sessions (“How often do you ask clients about their sexual issues?”)

Next, the interview was conducted with the LMHC. Considering the comments, several items were changed in the survey. An option was added to Question Number five to represent persons who are mostly spiritual and follow some religious dogma. Question Number six was modified to include “Many counselors have difficulty addressing sexual issues for a variety of reasons” because the LMHC reported that she felt “a little inadequate.” An option was also included to represent the midway point between comfort and discomfort. Because the LMHC’s reaction was “yuck” to Question Numbers 13 - 18, a statement was added before the question subset to better prepare the participant: “Comfort with sexual issues can vary widely based on the type of issue.” The options were changed on Question Numbers seven and eight to include more specific language rather than “often” and “sometimes.” Because she felt “a little inadequate” on Question Number 22 and “a little discomfort” on Question Number 28, the following verbiage was added to that particular group of questions: “There are many
reasons why counselors may be reluctant to address sexual issues with clients.” Question Number 28 was modified to specify “as compared to same gender.” Lastly, the first option for Question Number 33 was reworded for clarity: “Indicated that clients’ sexual issues were an appropriate topic for supervision.” Questions 13 through 18 were re-piloted with the LMHC, who reported that the rewording had addressed her discomfort, with one exception. The LMHC reported that after some reflection she realized it was the criminal aspects of the first two options that caused her discomfort, and since most therapists are not going to work with pedophiles or sexual predators, these options were removed and replaced with more common issues. More specifically, “pedophiles” and “sexual predators” were eliminated and “Sexual performance concerns,” “Sexual dysfunctions,” and “Sexual abuse” were added as these were the only topics mentioned as possible definitions of “sexual issues” in the LoFrisco and Hicks (2012) study not already included in this question.

Next, the interviews were repeated. According to Willis et al. (1999), optimally retesting is conducted until all major problems with the instrument are eliminated because a “questionnaire could be tested forever, and still have problems” (p. 30). Therefore, re-interviewing was performed until all major problems were resolved. First, the interview was re-administered with the LMHC. The only suggestion was to add an additional question, Question Number 33, asking if the supervisor provided support before asking what types of support were provided. This change was made. For all other questions, the LMHC reported that the questions were clear, thorough and non-offensive.
Next, the interview was repeated with the RMCI. The RMCI was re-interviewed after the LMHC due to scheduling issues. The RMCI reported no issues with any of the questions except for the suggestion of adding a “Not sure” option to Question Numbers 20 through 31, and changing the wording slightly from “please state why” to “If you can, please explain.” The RMCI also discovered that the question about sexual performance issues (Question Numbers 14 and 19) was repeated. Both of these changes were made. For all other questions, the RMCI reported that the questions were clear, thorough and non-offensive. Because this round of interviews did not uncover any major issues, it was determined to be the final round.

**Pilot study.** The survey was then uploaded to Survey Monkey and a link was sent to five people: a committee member who specializes in measurement, a master’s level student in the Counselor Education program at the University of South Florida, a psychologist, a licensed marriage and family therapist and a licensed mental health counselor. Feedback was generally very positive; indicating that the survey was easy to understand, flowed well, and was “user friendly.” However, there were some minor issues identified and corrected. These included adding more specific wording: “have you asked about sexual issues” was changed to “have you initiated a conversation about sexual issues” on Question Numbers 8 and 9; the term “Lack of Resources” was changed to “Lack of Access to Information,” and the term “Lack of Knowledge” was changed to “Lack of Formal and Informal Education” for Question Numbers 14 through 18; the term “Sexual Abuse” was changed to “Sexual Abuse (Survivors)” on Question Number 18; a request for explanation was added regardless of responses for Question Numbers 20 through 24; and the term “Supervision” was changed to “Supervision as an
intern” on Question Number 25. In addition, some problems in the skip logic were discovered and corrected.

**Procedures**

After approval from the University of South Florida Institutional Review Board, local mental health professionals were invited to participate in this study. Specifically, the survey was uploaded to Survey Monkey and a link to this survey was emailed to the participant list. The participant list consisted of the president of TBAMFT, the members from the online SMHCA directory, and the counselors located during the online search. Participants were offered the chance to win a $50 Amazon.com gift certificate in exchange for their participation, and anonymity was assured.

Multiple contact attempts have been determined to be the best way to increase participation (Dillman, Smyth, & Christian, 2009). According to social exchange theory, varied contacts are more effective than simply repeating the same message (Dillman et al., 2009). Therefore, multiple contacts were made. First, an initial email with the survey link was sent (Appendix F) to the participant list. Forty-two responses were received. Then, after two weeks, a follow-up email with the survey link was sent requesting the participation of those who had not yet taken the survey (Appendix G), which yielded 21 responses.

The verbiage is also important. Requests for participation should not be lengthy, nor include any extraneous information (Dillman et al., 2009). Requests that include information indicating the study is valuable, combined with explaining how the recipient’s participation is vital, is also likely to increase response rate (Dillman et al., 2009). Describing their anonymity is also a requirement, with brief assurances of
anonymity less likely to raise suspicion (Dillman et al., 2009). For the follow-up contact, detailing how other people have responded also increases response rate (Dillman et al., 2009). All of these suggestions were incorporated into the requests for participation (see Appendices F, G, and H).

After sending the initial email with the link it was discovered that the sweepstakes had not been added to the survey. This was immediately corrected, and verbiage was included in the follow-up email instructing those who had not had the opportunity to participate in the sweepstakes to reenter the survey by first either clearing their browser cache or using a different one. The data was then checked for duplicates, which were removed during the initial data cleanup (for more details see Chapter 4).

Investigator

The author is a Doctoral Candidate in a counselor education program at a large research extensive university. She is also a licensed mental health counselor, licensed marriage and family therapist, and certified sex therapist.

The desire to conduct this study arose mainly out of the problems presented by clients in her practice, but was augmented by previous research projects. Many clients reported sexual issues that had gone unresolved, either because they were too embarrassed to discuss them, or because previous therapists never initiated a discussion. Preliminary literature reviews seemed to indicate this was a more global problem. Furthermore, many of her clients reported early strict religious teachings that led them to feelings of shame or embarrassment about their sexuality, making discussion difficult.
The author has some several clinical assumptions based on these findings: a) religious fundamentalism creates shame and embarrassment about sexuality; b) attempts by clients to conform to strict religious or societal standards leads to repressed sexual feelings; c) these repressed sexual feelings create problematic sexual behaviors; and d) these problematic sexual behaviors inhibit the development of romantic relationships. Because there is a potential for the author’s bias to influence the survey questions, the survey was presented to the author’s major advisors for review, as well as reviewed by two other professional counselors.

**Trustworthiness**

Kline (2008) identified several characteristics that indicate quality in qualitative research, including trustworthiness (Lincoln & Guba, 1985). According to Lincoln and Guba (1985) qualitative research is trustworthy if it is credible, transferable, dependable, and confirmable. Several strategies were employed to ensure trustworthiness. First, to ensure credibility, only licensed counselors currently practicing were invited to participate. Second, the author's credentials helped ensure that the survey questions were relevant. Third, content validity was established via expert review and cognitive interviews with therapists.

Several strategies were also used to ensure quality. First, analytic procedures well documented in peer-reviewed literature were used. Second, providing sufficient information about the participants, including demographics, enhanced transferability so that readers can decide whether the findings are applicable to them. Third, explaining the procedures in detail, i.e. including the codebook, helped ensure dependability. Lastly, the triangulation of data helped ensure that it is confirmable. Using the qualitative
data to expand on and further explain the quantitative data helped confirm the accuracy of both. There are, however, some limitations regarding methodology.

**Limitations**

**Participant pool.** The participant pool was chosen based on either membership in two local professional organizations or the online presence of their practice, including ready access to email and the Internet. Additionally, counselors with an online presence solely represented by sponsored results were eliminated, because clicking on their link would have cost them money. Participation was also voluntary; therefore this sample may be biased towards counselors who are more vested in participating in research. Lastly, since only local counselors were selected for the pool, there may be cultural or environmental factors unique to this region that influence counselors, thus introducing bias in the sample. All of these factors limit the generalizability of this study.

Because counselors are expected to be tolerant and nonjudgmental, the participants may have answered the questions in such a way as to reflect this value, as opposed to how they honestly felt. Although participants were assured anonymity, social desirability bias could have still threatened the internal validity of this study. In addition, because participants may have had feelings of inadequacy as they recognized areas in which their skills may be deficient, rather than blame themselves they may have chosen to protect themselves by blaming their supervisors. Since the questions regarding their supervisory experience are at the end of the survey, their responses to these questions could be biased due to possible anger or disappointment created by the potential of increased awareness of clinical deficiencies resulting from answering the questions in Part II.
Survey. The survey was developed based on the information gathered from the literature review, a series of semi-structured interviews (LoFrisco & Hicks, 2012), the author’s clinical experience, and the feedback provided from the cognitive interviews. Because this information is of a qualitative nature and comes from a small sample, it may not represent all perspectives about the problem. This presents two possible issues. First, it is likely that all possible answers to the questions are not known at this time. Although open-ended options were provided in the survey to help address this problem, it is possible that the participant may not be able to manufacture an answer completely on their own as easily as they could from choosing a predefined option. Furthermore, the study participants may not understand the wording of the questions in the same way as the participants chosen for the cognitive interviews. These misunderstandings could cause the participant to answer inaccurately.

Summary

Chapter 3 described the study design and methodology, including a description of the sample, instruments, data collection procedures, and statistical analysis.
Chapter 4:

Results

The purpose of this study was to explore clinicians’ experiences with addressing clients' sexual issues in the context of the counseling relationship, as well as in the clinical supervisory relationship. A better understanding of these factors may lead to increased understanding of why counselors are failing to address clients’ sexual issues. The research questions were as follows:

1. What are counselors’ perceptions regarding how they addresses their clients' sexual issues?

2. What is the relationship between counselor comfort with clients' sexual issues and: counselor frequency of initiating sexual discussions, counselor professional identity, counselor gender, and counselor religious fundamentalism?

3. What are counselors’ perceptions regarding clinical supervisory support in addressing sexual issues with their clients?

In this chapter, the sample demographics are discussed. Next, descriptive statistics and other statistical results are included. Qualitative analyses are then presented descriptively and in a table (See Table 2), the hypotheses are discussed, and lastly a summary of the chapter is provided.
Initial Data Analysis

Upon termination of data collection, an initial total of 68 responses out of a possible 424 were received, making the response rate 16%. Forty-two (62%) responses were received as a result of the first study invitation, and an additional 26 (38%) responses were received as a result of the reminder to participate. As was explained in Chapter 3, several days after the initial email was sent, it was discovered that the sweepstakes were not set up. That was immediately rectified. The IRB was then consulted to formulate a follow-up corrective action to ensure that all participants had access to the sweepstakes. The IRB-approved plan was to add more verbiage to the reminder email inviting those who had participated in the survey but did not have the opportunity to enter the sweepstakes to retake the survey (see Appendix G). This action resulted in one duplicate entry, which was removed. In addition, other entries were removed to simplify data analysis: participants not currently practicing (n = 1), and participants with no data (n = 3). After this initial cleanup, there were a total of 63 participants. Due to the lack of new participants, it became apparent at this point that no other responses would be received, so the decision was made to terminate data collection.

In response to Question 13 (“How do you determine when sexual issues are beyond your comfort level?”), one participant specified “all of the above” under “other,” instead of selecting the categories individually. To correct this user error, one additional response was then added to each of the categories.

According to a Survey Monkey expert, it is possible for participants to use their browser’s back button to modify previous responses, thus skewing the data. The data
were examined and then corrected when needed. More specifically, it appeared that an extra participant answered Question 26 (“Did your supervisor provide support in addressing your clients’ sexual issues”). Thus, the extra response for Question 26 was deleted.

Another discrepancy was discovered when only one participant answered Question 11 (“Where do you refer clients with sexual issues?”) despite thirteen participants responding, “I refer out to an appropriate resource” to the previous question. According to a Survey Monkey expert, the skip logic (where survey monkey directs the user) on the first response selected takes priority over skip logic on subsequent response choices. Because multiple responses were permitted for Question 10, participants skipped to Question 12 if they indicated, “I discuss it” as one of the options, even if they also selected “refer out.” This was an error in setting up the survey; thus nothing can be done post-hoc to fix the data. As a result, conclusions cannot be drawn about counselor referrals for sexual issues.

**Study Sample**

Table 1 presents the demographic results. A total of 63 out of a possible 424 individuals participated in this study, making the response rate 16%. Forty-three (68.25%) reported gender as female and 20 (31.75%) reported gender as male. Regarding ethnicity, 57 (90.48%) reported Caucasian, four (6.35%) reported Hispanic, two (3.17%) reported African American, and two (3.17%) reported Native American. Due to an error in survey composition, multiple answers were permitted on this question; therefore the ethnicity responses total 65 instead of 63.

Regarding professional identity, 38 (60.32%) reported they were Licensed Mental
Health Counselors (LMHCs), 18 (28.57%) reported they were Licensed Marriage and Family Therapists (LMFTs), six (9.52%) reported they were Licensed Clinical Social Workers (LCSWs), four (6.35%) reported they were Registered Mental Health Counseling Interns (RMCHIs), three (4.76%) reported they were Registered Marriage and Family Therapy Interns (RMFTIs), three (4.76%) reported they were Psychologists, and two (3.17%) reported they were Sex Therapists. Additional certifications included Certified Addiction Professional (n = 1), Board Certified Art Therapist (n = 1), Clinically Certified Sex Offender Treatment Specialist (n = 1), Certified Hypnotherapist and ART (n = 1), Certified Relationship Specialist (n = 1), and Certified Psychodramatist (n = 1).

Regarding religion, most participants reported being Protestant (n = 28; 44.44%). Twelve (19.05%) participants reported being Catholic, and two (3.17%) reported being Jewish. Other responses included “Spiritual or Higher Power” (n = 6; 9.52%), Christian (n = 5; 7.94%), Buddhist (n = 3; 4.76%), not religious (n = 3; 4.76%), Lutheran (n = 1; 1.59%), “it’s complicated” (n = 1; 1.59%), Quaker (n = 1; 1.59%), and “All” (n = 1; 1.59%). Thus, participants, including those who self-reported as Protestant and Catholic, were mostly Christian (n = 47; 74.6%), with the next most common category cited as spiritual (n = 6; 9.52%).

Regarding religious fundamentalism, 29 (46.03%) reported considering themselves “mostly spiritual” and “not following a certain religion,” 17 (26.98%) reported following their religion “very seriously,” 16 (25.40%) reported following it “somewhat seriously,” and one (1.59%) claimed to be agnostic.
Table 1: Sample Demographics.

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<td></td>
<td></td>
</tr>
<tr>
<td>Protestant</td>
<td>28</td>
<td>44.44</td>
</tr>
<tr>
<td>Catholic</td>
<td>12</td>
<td>19.05</td>
</tr>
<tr>
<td>Jewish</td>
<td>2</td>
<td>3.17</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spiritual or Higher Power</td>
<td>6</td>
<td>9.52</td>
</tr>
<tr>
<td>Christian</td>
<td>5</td>
<td>7.94</td>
</tr>
<tr>
<td>Buddhist</td>
<td>3</td>
<td>4.76</td>
</tr>
<tr>
<td>Not Religious</td>
<td>3</td>
<td>4.76</td>
</tr>
<tr>
<td>Lutheran</td>
<td>1</td>
<td>1.59</td>
</tr>
<tr>
<td>It’s Complicated</td>
<td>1</td>
<td>1.59</td>
</tr>
<tr>
<td>Quaker</td>
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<td>1.59</td>
</tr>
<tr>
<td>All</td>
<td>1</td>
<td>1.59</td>
</tr>
<tr>
<td>Religious Fundamental</td>
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<tr>
<td>Mostly Spiritual</td>
<td>29</td>
<td>46.03</td>
</tr>
<tr>
<td>Follows Religion Very Seriously</td>
<td>17</td>
<td>26.98</td>
</tr>
<tr>
<td>Follows Religion Somewhat Seriously</td>
<td>16</td>
<td>25.40</td>
</tr>
<tr>
<td>Agnostic</td>
<td>1</td>
<td>1.59</td>
</tr>
</tbody>
</table>
Research Questions

Question 1. Research Question 1 of this study was “What are counselor perceptions regarding how he or she addresses their clients’ sexual issues?” In response to that question, most participants (n = 40; 63.49%) reported they were very comfortable addressing clients’ sexual issues, with most of the remainder (n = 20; 31.75%) reporting they were somewhat comfortable. Three (4.76%) reported they were comfortable about half the time, and no participants reported being very or somewhat uncomfortable. Thus, Research Hypothesis 1 is rejected.

Frequency of initiation. A majority of participants (n = 44; 69.84%) reported initiating sexual discussions at least half the time in their couples cases, and about half of them (n = 32; 50.79%) reported the same initiation rate in their individual cases. Approximately a quarter of participants (individuals: n = 14, 22.22%; couples: n = 12, 19.05%) initiate in about a quarter of the cases, regardless of type. Seventeen participants (26.98%) in individual cases compared with four (6.35%) in couples cases reported initiation less than ten percent of the time. Two participants (3.17%) reported they do not see couples and therefore did not answer the initiation question concerning couples cases.

Familiar issues. When asked how they handle sexual issues about which they are familiar, almost all (n = 62; 98.41%) participants reported they discussed it, with some (n = 20; 20.63%) reporting they also refer out. One participant reported that they ignore it, or tell the client they don’t handle these types of issues (1.59%, n = 1). Additional responses included recommending a physical exam (1.59%, n = 1), taking it as far as “the client is semi-comfortable with it” (1.59%, n = 1), and going slowly and
proceeding with caution (1.59%, n = 1).

As a follow-up question, participants were then asked where they would refer. Because of survey issues (please see Initial Data Analysis) only one answered. That participant reported they would refer to a sex therapist.

**Uncomfortable issues.** Concerning the handling of sexual issues that are beyond their knowledge or comfort level, a little more than half of the participants (n = 38; 60.32%) responded they would address the issue, consulting with experts as necessary. About half (n = 34; 53.97%) additionally reported they would tell the client they weren’t sure how to address the issue and would refer them out, and another fifth (n = 12, 19.05%) also reported they would tell the client they were not sure how to address the issue and then research it. Other responses included referring out to an expert or appropriate resource without specifying what they would tell client (n = 6; 9.52%), with one adding that first they would acknowledge the client’s issue and process for clarity (1.59%); it depends on the issue and it is not about the clinician’s comfort, but rather about client needs (n = 1; 1.59%); if there was a medical issue they would refer them out for a consult (n = 1; 1.59%); and clinician is knowledgeable with most issues and will suggest resources for the client as well (n = 1; 1.59%). No participants indicated that they would give minimal information and change the topic, or ignore it, or tell the client they do not address issues in this domain.

**Determining when issues are beyond comfort level.** The majority of participants (n = 53; 84.13%) reported that recognizing when they do not have the required knowledge is how they determine when sexual issues are beyond their comfort level. In addition, seven participants (11.11%) reported it was when they felt
embarrassed about the topic. Other responses included no discomfort (n = 4; 6.35%), discomfort under certain conditions (main area of focus: n = 1; 1.59%; sexual dysfunction: n = 1; 1.59%), insufficient knowledge or experience or medical training (n = 1; 1.59%), and referring out if necessary (n = 2; 3.17%).

**Specific topics.** Regarding specific topic, about two-thirds of the participants (n = 41; 65.08%) reported discomfort with the topic of sexual dysfunctions (see Figure 5); about half with sexual performance (n = 34; 53.07%) (see Figure 6), sexual acting out (n = 33; 52.3%) (see Figure 7), and sexual activities of GLBT persons (n = 32; 50.79%) (see Figure 8), and about a third (n = 32; 36.5%) with sexual abuse survivors (see Figure 9). Additional topics reported included sadism and masochism (n = 2; 3.17%), gender issues (n = 2; 3.17%), swinging (n= 1; 1.59%), sexual transference (n = 1; 1.59%), and orgasm techniques (n = 1; 1.59%).

Overall, lack of formal and informal education was the reason most cited as the cause of discomfort (Sexual Performance: n = 37, 58.73%; Sexual Dysfunctions: n = 34, 53.97%; Sexual Acting Out: n = 34, 53.97%; Sexual Activities of GLBT Persons: n = 25, 39.68%; Sexual Abuse (Survivors): n = 17, 26.98%). Lack of experience was the next most commonly cited (Sexual Dysfunctions: n = 28, 44.44%; Sexual Activities of GLBT Persons: n = 24, 38.95%; Sexual Performance: n = 23, 36.51%; Sexual Acting Out: n = 22, 32.92%; Sexual Abuse (Survivors): n = 17, 26.98%).

Please see the Figures 5 through 9, below, for more information.
Figure 5: Counselor discomfort with sexual dysfunctions.

Figure 6: Counselor discomfort with sexual performance.
Figure 7: Counselor discomfort with sexual acting out

Figure 8: Counselor discomfort with sexual activities of GLBT persons.
Figure 9: Counselor discomfort with sexual abuse (survivors).

**Appropriateness.** At this point in the survey, six participants exited early, therefore total participants is now 57 rather than 63. Of those 57, almost all the participants (n = 56; 98.25%) reported sexual issues were appropriate for therapy, but one participant (1.75%) reported they were not because they work with young children. When asked to elaborate, about two thirds of the participants (n = 36; 63.16%) reported they were a part of life; four (7.02%) indicated they were either the cause or symptom of other problems; three (5.26%) reported they were important to self-esteem, intimacy and relationships; one (1.75%) reported that they were relevant to their population of sexual abuse survivors; one (1.75%) reported they were important assets or detriments
to recovery from addictions; and one (1.75%) reported they were applicable most of the time, but not as a presenting issue. Nine participants (15.8%) failed to elaborate by indicating response was not applicable, or by simply repeating that they thought it was appropriate.

**Client gender.** Almost all participants (n = 54; 94.74%) reported being comfortable with working with the opposite gender on their sexual issues. Of those that responded they were uncomfortable (n = 3; 5.26%), one (1.75%) reported the possibility of sexual transference as the reason, and another (1.75%) reported that they were “more comfortable in heterosexual situations.” The third participant did not give a reason. One participant who reported they were comfortable also reported that they were uncomfortable discussing sexual performance with males when it involved a biological explanation. Other comfortable participants reported training in sex therapy (n = 3; 5.26%), professional experience (n = 3; 5.26%), and life experience (n = 1; 1.75%) as the reasons they are comfortable.

**Other inhibitors.** Participants had the option at the end of the survey to describe other inhibitors. Of those participants that answered the question (n = 22; 38.6%), the most common response was client discomfort (n = 5; 8.77%). The next most common response was concerns with legal issues due to the lack of a sex therapy certification (n = 3; 5.26%). Please see Table 2, below, for a complete list of the other inhibitors.
Table 2: Other Inhibitors.

<table>
<thead>
<tr>
<th>Inhibitor</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Discomfort</td>
<td>5</td>
<td>8.77</td>
</tr>
<tr>
<td>Legal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of Sex Therapy Certification</td>
<td>3</td>
<td>5.26</td>
</tr>
<tr>
<td>Pending Trials</td>
<td>1</td>
<td>1.75</td>
</tr>
<tr>
<td>Topics of Swinging, S&amp;M, and Prostitution</td>
<td>2</td>
<td>3.51</td>
</tr>
<tr>
<td>Treating Sex Offenders</td>
<td>2</td>
<td>3.51</td>
</tr>
<tr>
<td>Any Area With Little Knowledge or Experience</td>
<td>2</td>
<td>3.51</td>
</tr>
<tr>
<td>Details of Sexual Performance</td>
<td>1</td>
<td>1.75</td>
</tr>
<tr>
<td>Client Incapable of Discussion (i.e. Psychosis)</td>
<td>1</td>
<td>1.75</td>
</tr>
<tr>
<td>Values Differences</td>
<td>1</td>
<td>1.75</td>
</tr>
<tr>
<td>Client Seeking Shock Value</td>
<td>1</td>
<td>1.75</td>
</tr>
<tr>
<td>Not Presenting Issue With Couples</td>
<td>1</td>
<td>1.75</td>
</tr>
<tr>
<td>Topic of Corpses or Animals</td>
<td>1</td>
<td>1.75</td>
</tr>
<tr>
<td>Time Sensitive Services Unrelated to Sex</td>
<td>1</td>
<td>1.75</td>
</tr>
</tbody>
</table>

**Question 2.** Research Question 2 of the study was: “What is the relationship between counselor comfort with clients’ sexual issues and the following: counselor frequency of initiating sexual discussions, counselor professional identity, counselor gender, and counselor religious fundamentalism?” In answer to this question, a relationship was found between comfort level and frequency of initiation in individual cases, $\chi^2 (4, N = 63) = 9.53$, $p < .05$, but not in couples cases, $\chi^2 (6, N = 61) = 8.96$, $p > .05$. Please refer to Table 3 for more detail. Cramer’s V was calculated at .22 for individual cases. In these cases, a little more than half ($n = 25; 62.5\%$) of the very comfortable participants ($n = 40; 63.49\%$) raised the topic at least half the time, as compared to about a third ($n = 6; 30\%$) of the somewhat comfortable participants ($n = 20; 31.75\%$). In addition, a significant relationship was found between counselor gender and frequency of initiation of couples cases, $\chi^2 (3, N = 61) = 12.32$, $p < .01$. Cramer’s V was calculated at .44. There were no other significant findings.
Table 3: Chi-square Values.

<table>
<thead>
<tr>
<th></th>
<th>Comfort</th>
<th>Initiation-Individuals</th>
<th>Initiation-Couples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comfort</td>
<td>* 9.53 (df = 4)</td>
<td>8.96 (df = 6)</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>.04 (df = 4)</td>
<td>3.69 (df = 2)</td>
<td>12.32 (df = 3)**</td>
</tr>
<tr>
<td>Rel Fund</td>
<td>2.68 (df = 6)</td>
<td>3.14 (df = 6)</td>
<td>9.61 (df = 9)</td>
</tr>
<tr>
<td>Rel Type</td>
<td>1.53 (df = 4)</td>
<td>2.32 (df = 4)</td>
<td>2.43 (df = 6)</td>
</tr>
<tr>
<td>Prof Id</td>
<td>11.6 (df = 12)</td>
<td>15.78 (df = 12)</td>
<td>15.94 (df = 12)</td>
</tr>
</tbody>
</table>

* = significant at the .05 level
** = significant at the .01 level

**Professional identity.** Comfort. Two (33%) of the interns (n = 6; 9.52%) reported being very comfortable, compared to about double that percentage (n = 37; 64.91%) of licensed professionals (n = 57). Roughly equal percentages (n = 26, 68.42%; n = 14, 77.78%) of LMHCs (n = 38) and LMFTs (n = 18) reported they were very comfortable. Somewhat fewer (n = 3; 50%) of LCSWs (n = 6) and one out of three (33.33%) Psychologists reported they were very comfortable. The results of a chi-square test reveal no significant differences in comfort, however, \( \chi^2 (12, N = 63) = 11.6, p > .05 \).

Initiation. Sample sizes in this section are reported as subsamples categorized by professional identity. Concerning frequency of initiation of the topic, slightly more than half (n = 32; 56.14) of licensed participants (n = 57; 90.48%) raised the topic of sexual issues in at least half of their individual cases; whereas 70% (n = 40) of licensed participants (n = 57; 90.48%) raised the topic in at least half of their couples cases. None of the interns (n = 6) reported raising the topic in at least half of their individual cases, and four (67%) reported raising the topic in at least half of their couples cases.
The rate of initiation of both individual and couples cases was not found to vary by professional identity, $\chi^2 (12, N = 62) = 15.78, p > .05; \chi^2 (12, N = 61) = 15.94, p > .05$.

**Counselor gender. Comfort.** No significant relationship was found between counselor gender and comfort level, $\chi^2 (4, N = 63) = .04, p > .05$. More specifically, similar percentages of both males and females reported comfort at all levels. Please see Table 4 for more detail.

<table>
<thead>
<tr>
<th></th>
<th>Comfortable</th>
<th>Somewhat Comfortable</th>
<th>Comfortable About Half the Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>65% (n = 13)</td>
<td>30% (n = 6)</td>
<td>5% (n = 1)</td>
</tr>
<tr>
<td>Female</td>
<td>62.79% (n = 27)</td>
<td>32.56% (n = 14)</td>
<td>4.65% (n = 2)</td>
</tr>
</tbody>
</table>

**Initiation.** No significant relationship was found between counselor gender and frequency of initiation of individual cases, $\chi^2 (2, N = 63) = 3.69, p > .05$, but a significant relationship was found with couples cases, $\chi^2 (3, N = 61) = 12.32, p < .01$. Cramer’s V was calculated at .44. Sixty percent (n = 25) of females (n = 42; 66.67%) as compared to 35% (n = 7) of males (n = 20; 31.75%) reported raising the topic at least half the time in couples cases.

**Religious Fundamentalism. Comfort.** No significant relationship was found between religious fundamentalism and comfort, $\chi^2 (6, N = 63) = 2.68, p > .05$, nor between religion type and comfort, $\chi^2 (4, N = 42) = 1.53, p > .05$. 

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Initiation. No significant relationship was found between religious fundamentalism and initiation in individual cases, \(\chi^2 (6, N = 63) = 3.14, p > .05\), nor in couples cases, \(\chi^2 (9, N = 61) = 9.61, p > .05\). No significant relationship was found between religion type and initiation in individual cases, \(\chi^2 (4, N = 42) = 2.32, p > .05\), nor in couples cases, \(\chi^2 (6, N = 42) = 2.43, p > .05\).

Thus, a positive relationship was found between counselor comfort with clients' sexual issues and counselor frequency of initiation in individual cases, and also between counselor gender and frequency of initiation in couples cases. No other significant relationships were found. Therefore, Research Hypothesis 2 is partially supported.

**Question 3.** Research Question 3 of the study was: “What are counselor perceptions regarding supervisory support in addressing sexual issues with his or her clients?” To ensure accuracy of data, participant data was only collected for those participants (n = 18; 28.57%) who reported that they have had supervision within the past ten years. Therefore, unless otherwise specified, for this section all percentages will be based on an N of 18, rather than 63.

A slight majority of participants reported receiving support from their supervisors (n = 11; 61.11%) in addressing their clients' sexual issues. The remainder reported “none” or “minimal” support (n = 7; 38.89%). Out of these participants (n = 7; 38.89%), most (n = 6; 33.33%) reported it was because they didn’t ask their supervisor about those kinds of issues, and one (5.56%) reported they did ask but the supervisor was not responsive. Two (11.11%) additionally reported it didn’t come up in discussions, and one (5.56%) reported services were limited to sexual trauma. Please see Figure 10.
Out of the six (33.33%) participants who reported they didn’t ask their supervisor about sexual issues, five (27.78%) reported they didn’t have any clients with sexual issues. One participant (5.56%) responded, “He never asked but he was writing a book about putting romance into a relationship.” One participant (5.56%) also reported the supervisory environment did not feel safe. Figure 10 is a flowchart representation of these results. Thus, because a slight majority of participants reported receiving support from their supervisor, Research Hypothesis 3 is mostly rejected.

**Q26. Did your supervisor provide support in addressing your clients’ sexual issues? (n = 18)**

- Yes (n = 11)
- No (n = 7)

**Q27. If your supervisor was not supportive, please select all that apply (n = 7)**

- I didn’t ask (n = 4)
- Other (n = 2)
- I asked, but supervisor not supportive (n = 1)

**Q28. I didn’t ask my supervisor about my clients’ sexual issues because: (n = 6)**

*Figure 10:* Supervisor support responses.
Eighteen out of 63 participants answered the questions in this portion of the survey. Therefore N will be 18 instead of 63. In response to the question of how supervisors can be supportive in helping their supervisees address their clients’ sexual issues, half (n = 9) of the participants reported indicating that clients’ sexual issues are an appropriate topic for supervision as most important, more than any other reason. Seven (38.89%) chose “discussed my own comfort level,” six (33.33%) participants chose “provided educational materials/instruction on sexual issues,” and six (33.33%) chose “helped me process my own internalized views relative to sexuality” (see Figure 11).

**Figure 11**: How supervisors can support supervisees. Note that 1 = least important and 5 = most important.
Although the prompt “indicated that clients’ sexual issues are an appropriate topic for supervision,” had the highest percentage of “very important” responses, it does not necessarily mean that was the only salient response. Another way to view these data is to assign points to importance, with one point for least important and five points for most important. When viewed in this manner, each item appears to have almost equal importance. Table 5 depicts these totals:

Table 5: Supervisory Support Importance Totals.

<table>
<thead>
<tr>
<th>Method of Support</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicated that clients’ sexual issues are an appropriate topic for supervision</td>
<td>73</td>
</tr>
<tr>
<td>Discussed my comfort level in addressing sexual issues</td>
<td>72</td>
</tr>
<tr>
<td>Provided educational materials/instruction on sexual issues</td>
<td>67</td>
</tr>
<tr>
<td>Helped me to process my own internalized views relative to sexuality</td>
<td>66</td>
</tr>
</tbody>
</table>

Support for Hypotheses

The tentative hypotheses for this study were:

H₀: Most counselors do not feel uncomfortable addressing their clients’ sexual issues.

H₁: Most counselors feel uncomfortable addressing their clients’ sexual issues.

H₀: No relationship exists between counselor comfort with clients’ sexual issues and the following: counselor frequency of initiating sexual discussions, counselor professional identity of sex therapist, counselor gender of female, and religious fundamentalism.

H₂: There will be a positive relationship between counselor comfort with clients’ sexual issues and the following: counselor frequency of initiating sexual discussions, counselor professional identity of sex therapist, and counselor gender of female; and a
negative relationship between counselor comfort with clients' sexual issues and religious fundamentalism.

$H_0$: Counselors do not feel unsupported by their supervisors in addressing clients’ sexual issues.

$H_3$: Counselors feel unsupported by their supervisors in addressing clients’ sexual issues.

**Hypothesis 1.** Most participants ($n = 40; 63.49\%$) reported they were very comfortable addressing clients’ sexual issues, with most of the remainder ($n = 20; 31.75\%$) reporting they were somewhat comfortable. Therefore, almost all participants ($n = 60; 95.24\%$) reported what could be considered reasonable levels of comfort with sexual topics. Therefore, the null hypothesis is accepted.

**Hypothesis 2.** There are limited data to support Research Hypothesis 2. Significant positive relationships were found between comfort and initiation of individual cases, $\chi^2 (4, N = 63) = 9.53, p < .05$, and female gender and initiation of couples cases, $\chi^2 (3, N = 61) = 12.32, p < .01$. However, no significant relationship was found between comfort and initiation of couples cases, professional identity of sex therapist, counselor gender of female, or religious fundamentalism. Thus, the null hypothesis is partially rejected.

**Hypothesis 3.** Because a majority of participants ($n = 11; 61.11\%$) reported receiving support from their supervisors, the null hypothesis is mostly accepted.

**Summary**

Descriptive statistics and qualitative data were analyzed. Quantitative data were measured using chi-square. Findings from this study are summarized in Table 6.
Figures 5 through 9 depict specific topics that make counselors uncomfortable and Figure 10 depicts how supervisors can support supervisees. Specific chi-square values are provided in Table 3.

**Table 6: Summary of Study Results.**

<table>
<thead>
<tr>
<th>Research Question</th>
<th>Findings</th>
</tr>
</thead>
</table>
| 1. “What are counselor perceptions regarding how he or she addresses their clients’ sexual issues?” | - Almost all participants (n = 56; 98.23%) reported sexual issues are appropriate to discuss in therapy  
- Most (n = 40; 63.49%) reported they were very comfortable  
- The majority (n = 44; 69.84%) reported initiating the discussion of sexual issues in at least half of couples cases  
- Half (n = 32; 50.79%) reported initiating the discussion of sexual issues in at least half of the individual cases  
- Almost all reported discussing issues with which they were familiar (n = 62; 98.41%)  
- No participants reported ignoring issues with which they were not comfortable or have little knowledge of, they would discuss and/or refer out  
- Most participants (n = 53; 84.13%) reported lack of knowledge as their indicator of discomfort  
- The topic causing the most discomfort was sexual dysfunctions (n = 41; 65.08%) |
| 2. “What is the relationship between counselor comfort with clients’ sexual issues and the following: counselor frequency of initiating sexual discussions, counselor professional identity, counselor gender, and counselor religious fundamentalism?” | - A significant positive relationship was found between gender of female and initiation in couples cases, \( \chi^2 (3, N = 61) = 12.32, p < .01 \)  
- A significant positive relationship was found between a comfort level and frequency of initiation in individual cases, \( \chi^2 (4, N = 63) = 9.53, p < .05 \)  
- No significant relationship were found between religious fundamentalism and |
### Table 6 (continued)

<table>
<thead>
<tr>
<th>Research Question</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>initiation in couples cases, $\chi^2 (9, N = 63) = 9.61, p &gt; .05$, individual cases, $\chi^2 (6, N = 63) = 3.14, p &gt; .05$, or comfort with sexual topics, $\chi^2 (6, N = 63) = 2.68, p &gt; .05$</td>
<td>• No significant relationship were found between counselor gender and initiation in individual cases, $\chi^2 (2, N = 63) = 3.69, p &gt; .05$, or comfort with sexual topics, $\chi^2 (4, N = 63) = .04, p &gt; .05$</td>
</tr>
<tr>
<td></td>
<td>• No significant relationships were found between professional identity and comfort with sexual topics, $\chi^2 (12, N = 63) = 11.6, p &gt; .05$, initiation in couples cases, $\chi^2 (12, N = 63) = 15.94, p &gt; .05$, or initiation in individual cases, $\chi^2 (12, N = 63) = 15.78, p &gt; .05$</td>
</tr>
<tr>
<td></td>
<td>• No significant relationship was found between comfort with sexual topics and initiation in couples cases, $\chi^2 (6, N = 63) = 8.96, p &gt; .05$</td>
</tr>
<tr>
<td>3. “What are counselor perceptions regarding supervisory support in addressing sexual issues with his or her clients?”</td>
<td>• This section has 18 rather than 63 participants</td>
</tr>
<tr>
<td></td>
<td>• A little more than half of the participants (n = 11; 61.11%) reported receiving support</td>
</tr>
<tr>
<td></td>
<td>• A little less than half of the participants (n = 7; 38.89%) reported receiving “none or minimal” support</td>
</tr>
<tr>
<td></td>
<td>• Six (33.33%) participants reported not having clients with sexual issues</td>
</tr>
<tr>
<td></td>
<td>• Indicating that clients’ sexual issues are an appropriate topic for supervision was selected more than any other (n = 9; 50%) as the most important thing supervisors can do to be supportive</td>
</tr>
</tbody>
</table>
Results of the chi-square calculations were mixed. Two significant relationships were found, one between gender of female and initiation in couples cases, $\chi^2 (3, N = 61) = 12.32, p < .01$, and the other between comfort level and frequency of initiation in individual cases, $\chi^2 (4, N = 63) = 9.53, p < .05$. No other relationships were found. Thus, Research Hypothesis 2 was partially supported. Chapter 5 will discuss these findings as well as limitations of the study, suggestions for future research, implications for the field and final conclusions.
Chapter 5:
Discussion

The prevalence of sexual issues has been reported at forty-three percent for women (Shifren et al., 2008) and thirty-one percent for men (Laumann et al., 1999). Failure to address sexual issues can result in harm to clients (Blanchflower & Oswald, 2004; Harris & Hays, 2008; Juergens et al., 2009; Laumann et al., 2006). Therefore, sexual issues are both common and salient issues for clients.

Comfort

Almost all of the participants reported they were comfortable discussing sexual topics with clients, with 63.49% (n = 40) reporting “very comfortable,” and 31.7% (n = 20) reporting “somewhat comfortable.” This finding contrasts rather sharply with Mollon (2005) and Shadbolt (2009) in that it suggests that sexual shame may not be as salient as these researchers thought. Possible reasons for this discrepancy include bias. Shadbolt self-identifies as a lesbian, therefore it is possible this author has felt discrimination and rejection due to her sexual orientation, which could have led to an increased association between sexuality and shame. In addition, because Mollon (2005) referred to sexual shame using Freud’s theory as context, it is possible that this author would attribute this discrepancy to repression of sexual shame. Further, Freud’s theory is not empirically supported.
Frequency of Initiation

The data from this study suggest that many counselors fail to initiate discussions about sexual issues with clients, particularly with individual clients. More specifically, about half of the participants (n = 31; 49.2%) reported initiating sexual topics in 25% or less of their individual cases. The frequency was somewhat greater in couples cases, with only a quarter of the participants (n = 17; 26.98%) reporting initiation rates of 25% or less. Considering the importance and prevalence of sexual issues, these numbers should be much lower.

Many researchers have linked lack of initiation with discomfort (Harris & Hays, 2008; Hartl et al., 2007; Juergens et al., 2009; Papaharitou et al., 2008; Ridley, 2006; Weerakoon et al., 2004; Weerakoon, et al., 2008). A significant relationship between comfort level and frequency of initiation in individual cases, $\chi^2 (4, N = 63) = 9.53, p < .05$, was found in this study, supporting the work of these researchers. If clinicians are failing to initiate conversations, and lack of initiation has been connected with discomfort, it would logically follow that discomfort is the cause for the lack of initiation. Yet, this study found almost all of the participants reporting they were comfortable discussing sexual topics with clients, with 63.49% (n = 40) reporting “very comfortable,” and 31.7% (n = 20) reporting “somewhat comfortable.”

There are four possible explanations for this disparity. First, it is possible that the participants actually were more uncomfortable than they reported. Perhaps they were not aware of their internalized negative feelings about sexuality, or they were not truthful about their comfort level due to social desirability bias. The survey relied on self-report, and perhaps some of the participants feared admitting they were uncomfortable with
such an important topic. Consider these comments from two participants who stated they were “very comfortable” with discussing sexual issues: “I state facts, give stories, try humor if they are open to it.” Additionally,

“Go slowly to identify the actual issue, there are MANY underlying and unconscious conflicts and reality that are simply unknown. Must proceed with caution, careful to note body language, affect, posturing, dissociative process and possible eruption of traumatic memories.”

Are these counselors projecting their own discomfort? Why the need for so many safeguards if the counselor is comfortable with the topic?

Second, perhaps the theoretical orientation of the counselor is inhibiting the initiation of sexual topics. More specifically, counselors who practice a client-centered type of therapy, also known as Rogerian therapy, believe in allowing the client to determine what gets discussed in the counseling session. These counselors would not raise a topic themselves because that would be considered too directive for this type of therapy.

Third, it is possible that lack of comfort is not the problem. Both Arnold (1980) and Harris and Hays (2008) found a connection between knowledge and willingness. However, research also suggests that that increasing knowledge does not increase comfort (Arnold, 1980; Decker, 2010; Ford & Hendrick, 2003; Harris & Hays, 2008), which could imply that increasing knowledge is not important. Perhaps they are asking the wrong question. Maybe counselor comfort is not a requirement for addressing sexual issues effectively. Therefore, perhaps it is lack of knowledge that is the cause of not initiating these topics. For example, one participant commented: “it’s not about my
comfort, but their needs” in response to Question 12, which asked, “What do you do when a client raises a sexual issue beyond your knowledge or comfort level?”

Fourth, another possibility is lack of time or lack of purview. For example, one participant reported that they didn’t ask their supervisor about sexual issues because only services related to sexual trauma were provided. This implies that the participant does not address sexual issues during the counseling session, and therefore does not need the support. Yet, it logically follows that sexual trauma would affect a person’s sexuality. Therefore, perhaps the reasons these issues are not addressed has more to do with lack of time, or a limitation in the scope of services, or an entirely different factor that has not been studied yet.

**Gender**

Researchers disagree regarding the effect counselor gender has on comfort with sexual topics. More specifically, Fluharty (1996) found male counselors less comfortable with sexual topics, Berman (1996) and Decker (2010) found no difference, and Ford and Hendrick (2003), and Haag (2009) found male therapists more comfortable. Although this study found no relationship between gender of participant and comfort with sexual topics, a significant relationship was found between gender and initiation of topic in couples cases, $\chi^2 (3, N = 61) = 12.32, p < .01$, with females being more willing to initiate the discussion. Female sex drive is affected by outside influences, such as relationship issues and stress, to a much larger degree than male sex drive. Thus, female sexuality exists in the context of its environment. Because females conceptualize their own sexuality as contextual, they are likely to conceptualize their clients’ sexuality in the same way. Therefore, when a couple presents for therapy,
the female counselor is more likely to recognize how relationship factors can affect sexuality, and so sexuality becomes part of the presenting concern, even if the couple never brings it up. Returning to the previous discussion of the role of comfort, this discrepancy also suggests that either comfort is not required to initiate the topic, or it was over-reported in the sample.

**Religious Fundamentalism**

Despite some research linking religious fundamentalism with sexual discomfort, (Ahrold & Meston, 2010; Baier & Wampler, 2008; Barkan, 2006; Cowden & Bradshaw, 2007; Daniluk & Browne, 2008; Gravel et al., 2011; Hull, 2008; Kwee & Hoover, 2008, Papaharitou et al., 2008; Schwartz & Lindley, 2009), no significant relationship was found in this study. Perhaps asking participants if they “followed their religion seriously” was not the best way to determine religious fundamentalism. The question should have asked about rigidly following the rules as opposed to the more general question of following their religion. Perhaps it is the rigid thinking process in general rather than a strong identification to organized religion that is at issue.

**Specific Topics**

If it were true that clients perceive certain therapists as homophobic (Palma & Stanley, 2002), or that therapists are uncomfortable about the sexual activities of transgendered persons (Rutter et al., 2010), then the results from this study would have shown that the topic of sexual activities of GLBT persons were the most problematic for therapists. Although it can be argued that the findings of this study support the work of Palma and Stanley (2002) and Rutter et al. (2010), in that therapists did report discomfort with sexual activities of GLBT persons, many other sexual topics were also
found to cause discomfort. Therefore, it cannot be concluded that therapist discomfort is caused by homophobia. Rather, a possible conclusion is that therapists are somewhat uncomfortable with sexual topics in general.

It should be noted that the breadth of topics on the survey was reasonably complete. Although a few other topics were cited as problematic, such as sadism and masochism \((n = 2; 3.17\%)\) and gender issues \((n = 2; 3.17\%)\), a strong majority of participants expressed their discomfort as being with the topics specified on the survey.

**Education**

This study supports the assertion by many researchers that education about sexual issues increases comfort \((Berman, 1996; Harris & Hays, 2008; Juergens et al., 2009; Kazuakuskas & Lam, 2010; Papaharitou et al., 2008; Post et al., 2008; Simpson et al., 2006; Weerakoon et al., 2008)\). More than any other reason, participants reported lack of formal and informal education as the source of their discomfort with specific sexual topics \((Sexual Performance: n = 37, 58.73\%; Sexual Dysfunctions: n = 34, 53.97\%; Sexual Acting Out: n = 34, 53.97\%; Sexual Activities of GLBT Persons: n = 25, 39.68\%; Sexual Abuse (Survivors): n = 17, 26.98\%)\). Although the state of Florida requires the completion of a graduate class in Human Sexuality, this course covers a lot of general information about human sexuality, including history and cultural implications. It appears that more education on problems in adult sexuality is required. Further, this lack of education could be the primary reason for the lack of comfort with sexual topics rather than personal embarrassment \((Sexual Performance: n = 22, 34.92\%; Sexual Dysfunctions: n = 19, 30.16\%; Sexual Acting Out: n = 17, 26.98\%; Sexual Activities of GLBT Persons: n = 18, 28.57\%; Sexual Abuse (Survivors): n = 17, 26.98\%), or religious
beliefs (Sexual Performance: n = 18, 28.57%; Sexual Dysfunctions: n = 17, 26.98%; Sexual Acting Out: n = 18, 28.57%; Sexual Activities of GLBT Persons: n = 19, 30.16%; Sexual Abuse (Survivors): n = 15, 23.81%).

**Supervisory Support**

Research suggests that supervisor support is essential in helping supervisees feel more comfortable with sexual topics (Harris & Hays, 2008; Hays, 2002) and to increase initiation levels (Berman, 1996). Yet, out of the 18 participants that answered this section of the survey, more than a third (n = 7; 38.89%) reported “none” or “minimal” support. Although participants reported being very comfortable with sexual issues, other data from the survey, including initiation rates, indicate otherwise. Therefore, it is possible that lack of supervisory support could be a reason that some counselors fail to address sexual issues.

Out of these participants (n = 7; 38.89%), most (n = 6; 33.33%) reported it was because they didn’t ask their supervisor about those kinds of issues. Some researchers (Hartl et al., 2007; Heru et al., 2004; Morgan & Porter, 1999) suggest this is due to personal discomfort. However, results from this study do not support this conclusion. None of the counselors who reported not asking supervisors about sexual issues (n = 6; 33.33%) reported discomfort as the reason.

Nonetheless, it is still important for supervisors to assure their supervisees that sexual issues are an appropriate topic in supervision. Just as sexual shame and embarrassment may inhibit clients from initiating these conversations, they also can inhibit supervisees. Data from this study suggest this as well. The response, “Indicate that clients’ sexual issues are an appropriate topic for supervision,” was cited as most
important (n = 9; 50%), more than any other reason.

Regarding the importance of education, six (33.33%) participants chose “provided educational materials/instruction on sexual issues,” as an important way that supervisors could support their supervisees. Overall, out of four choices, it was ranked third, behind “Indicated that clients’ sexual issues are an appropriate topic for supervision” and “Discussed my comfort level in addressing sexual issues.” These results, combined with previous results indicating lack of formal and informal education as a primary reason for discomfort, suggest the importance of supervisors educating their supervisees.

Conclusions

Sexual issues are common, and are often not addressed in counseling. Unaddressed sexual issues can be harmful to clients. Therefore, it is important to understand why these issues are not being addressed. Although previous studies seem to indicate discomfort and lack of knowledge as the causes, there were conflicting and incomplete data. Therefore, one purpose of this study was to address those missing areas.

Although a connection was found between comfort and initiation, results were mixed regarding comfort. Although almost all (n = 60, 95.24%) participants reported being comfortable with addressing sexual issues (very: n = 40, 63.5%; somewhat: n = 20, 31.7%), many reported a failure to initiate sexual discussions with clients, particularly in individual cases (n = 31, 49.21%). Perhaps other factors are affecting the initiation rates, such as lack of knowledge, or some participants interpreted the question about comfort differently.
Because supervisors are so integral to a professional counselor’s development, supervision is a logical place to help clinicians increase their comfort and knowledge. Yet, little or no research had been done in this area. Thus, another purpose of this study was to explore how clinicians found their supervisors helpful.

Because the number of participants (n = 18) was so small for this section of the survey, drawing conclusions is problematic. Considering the limited number of responses, results from this study indicate that some (n = 7; 38.89%) clinicians do not find supervisors helpful, with about half reporting that it was because they did not ask their supervisors about sexual issues. Because supervisors are perceived as mentors, it is really up to them to initiate these types of conversations. Therefore, supervisors can be more helpful by instructing their supervisees that their clients’ sexual issues are an appropriate topic in supervision.

Limitations

There are two major and one minor limitation to this study. The two major limitations are power and generalizability. The minor limitation involves integrity of data.

Power. A post hoc analysis of the data revealed that the originally planned statistical method of regression was not appropriate due to the categorical nature of the dependent variables and the decision was made to calculate chi-square test of independence instead (Grimm, 1993). Therefore the required sample size stated in Chapter 3 (n = 85) is no longer relevant. Instead, Cramer’s V (Everitt & Skrondal, 2010; Vogt, 1999) was calculated. Cramer’s V measures the association between categorical variables using values ranging from zero to one. The calculated values for the two significant findings were mixed. For counselor gender and initiation in couples cases, Cramer’s V was calculated at .44, indicating a moderate association (Crewson, 2006).
For counselor comfort and initiation of individual cases, Cramer’s V was calculated at .22, indicating a low association (Crewson, 2006). In addition, several of the cells of the frequency tables had less than five entries (gender and initiation of couples cases: 63%, comfort and initiation of individual cases: 44%), threatening the validity of the results (Grimm, 1993).

Lastly, Part 3 of this study had eighteen participants. Due to the extremely low participation on this section of the survey, only preliminary conclusions can be drawn regarding counselor’s supervisory experiences.

**Generalizability.** The second major limitation to this study is its generalizability. First, participant self-selection bias is possible since the study invitation clearly stated its purpose. Therefore, it is possible that those who were comfortable with the topic and understood its importance were more likely to respond to the invitation. Second, all the participants were from Tampa, Florida. In addition, the ethnicity of the sample was not representative of the U.S. population. More specifically, there were a disproportionate amount of Caucasian participants as compared to other ethnic groups, particularly African American. According to the U.S. Census Bureau (2008), the U.S. population is 78.1% White, as compared to 90.48% in this study. The most underrepresented ethnic groups were African American (U.S. population: 13.1%; study: 3.17%) and Hispanic (U.S. population: 16.7%; study: 6.35%).

Another issue with generalizability involves professional identity. Small numbers of licensed clinical social workers (n = 6; 9.54%), psychologists (n = 3; 4.76%), sex therapists (n = 2; 3.17%), and interns of all types (n = 7; 11%), make drawing conclusions about those groups problematic.
**Data integrity.** A minor issue with this study involves the integrity of the data. First, six participants (9.52%) skipped Questions 20 through 25. It is possible that they also missed Questions 14 through 19, but it is impossible to determine since responses to those questions were optional by design. Therefore, depending on the characteristics of these participants, it is possible that the data for these questions are slightly skewed. Second, because some participants incorrectly skipped Question 11 due to a survey problem, conclusions cannot be drawn about where these counselors refer their clients. Third, because Question 4 incorrectly allowed multiple responses, the ethnic demographics are slightly inaccurate.

Because more than one answer was permitted, some questions yielded confusing results. More specifically, on Question 10, “What do you do when a client raises a sexual issue about which you are familiar?” and Question 12, “What do you do when a client raises a sexual issue beyond your knowledge or comfort level?” twelve and nine people, respectively, responded that they would both address the issue and refer out. Perhaps this meant that certain issues would be referred out, but it is impossible to determine.

Lastly, the ability to use the back button to return to previous questions could have affected the ordering of the questions. Rather than answer them in the order provided, it was possible for participants to skip around. As a result, some of the answers on some of the questions may have been skewed. For example, if after answering the last section on supervision, if the participant was angry or upset by thinking about the lack of support they received, they may have gone back to an earlier question and stated their sexual discomfort as higher than it actually was.
Suggestions for Future Research

The discrepancy between initiation and comfort needs to be addressed further. The use of a validated instrument may yield a more accurate measure of comfort. In addition, the use of neurofeedback may be useful in interpreting survey answers, as it was in the Bonnstetter, Collura, Hebets, and Bonnstetter (2012) study. According to these researchers (Bonnstetter, Collura, Hebets, & Bonnstetter, 2012) certain brainwave balances suggest negative feelings, which can then be compared to given answers. In this way, these researchers (Bonnstetter, Collura, Hebets, & Bonnstetter, 2012) were able to uncover possible discrepancies and ask more appropriate follow-up questions. Since biological data are objective, this information may help to eliminate social desirability bias.

There may be factors other than comfort affecting initiation. Knowledge, for example, needs to be considered in more depth. Other constructs could be gender and type of case. This study found a significant correlation between gender of female and initiation in couples cases, but not in individual cases. This suggests a future research question: why is initiation higher in couples cases for female counselors? Gender and/or type of case could also be factors that affect frequency of initiation. For example, perhaps females are more reticent in individual cases due to the possibility of sexual transference.

Willingness to discuss sexual issues and frequency of initiation may not be the same thing, although both affect addressing clients’ sexual issues. Future research should address these constructs separately. Perhaps clinicians are willing, but are unable to address these issues due to time or purview constraints.
It would also be interesting to discover if there is a difference between practitioners in private practice and those that work at an agency. Due to time pressures at an agency, it seems reasonable to assume that only the minimum, i.e. the presenting concern, is addressed. This could be another reason that some clients aren’t getting their sexual issues addressed; and could partially address the discrepancy between comfort and initiation as well. Also, a possible connection between professional identity and willingness to discuss sexual issues needs to be explored by including more social workers and psychologists.

In addition, more data needs to be collected on counselor’s supervisory experiences. One suggestion would be to widen the criteria to allow participants to answer questions about their supervisory experiences even when more than ten years has passed, while giving them the option to indicate if they cannot remember to ensure data integrity. An alternative, and perhaps better suggestion, would be to recruit counseling interns nationwide. This way, not only are we assured that their memories are recent, but they may receive additional benefit as they process the questions. Namely, they may realize that asking their supervisor about sexual issues is both acceptable and important! Also they could be broken down by state to see if there are any regional differences in the data. If so, supervision training program suggestions could be made for all states.

Lastly, supervisors themselves need to be studied and more information needs to be gathered regarding what kind of support they are providing to their supervisees, and how they educate their supervisees about what topics are appropriate for supervision. The limited information gained from Part 3 of this study, combined with the data from
the LoFrisco and Hicks (2012) study could be used to develop a questionnaire that could be used in future research.

**Future surveys.** Perhaps future surveys should contain more global questions about counseling practice so that not just those interested in sexual topics would be encouraged to participate, thus eliminating self-selection bias. In addition, one modification that should be made to the instrument is to separate Question 18, which asks about discomfort with the topic of sexual abuse, into two sections. One section would ask about discomfort with working with victims of sexual abuse and the other would ask about working with perpetrators. Another recommended modification is a more granular breakdown on the upper end of the options for Questions 8 and 9, which ask about frequency of initiation. Instead of just one option indicating “More than half of the cases,” recommended options to add include “All of the cases, with rare exceptions,” “The majority of cases,” and “About half of the cases.” In addition, the verbiage on Question 6, asking about religious fundamentalism, needs to be changed to verbiage that asks about rigid adherence to rules. Lastly, a question could be added to the survey asking if the participant’s religion inhibits them from initiating sexual discussions with their clients.

**Implications for the Field**

This study, along with similar previous studies, has highlighted the importance of addressing sexual issues because of the positive effect it has on the well being of clients seeking professional mental health services. This study also provides important preliminary research into the cause of the failure to address sexual issues. Although previous studies had been done, there were conflicting data and missing pieces of
information. In some ways this study has helped to fill in those missing parts, but mostly it raises more questions, and provides an important platform for future work.

A few more specific implications can be noted, however. For example, therapists may need education about the legalities of practicing sex therapy. Although just a few participants \( n = 3; 5.26\% \) reported this as an inhibitor, the law may be confusing because the title “sex therapy” is protected, rather than the practice. As long as they are practicing within their bounds of competency, there is no legal issue with addressing sexual issues.

One important implication of this study is that interns need to advocate for themselves. Because it is unlikely their supervisor will raise the topic, interns need to take the initiative in asking for support with their clients’ sexual issues. Interns should understand it is their right to receive such support from their supervisors.

Due to the importance of sexual education, and the lack of a requirement for sexual education beyond a graduate level course, it is also important for both interns and therapists to self-educate. However, it may be difficult to accomplish this. Although a graduate course in Human Sexuality is required by the state of Florida for licensure, it should be considered more as an introduction to the topic. Because of the wide range of sexual topics (i.e. contraception, sexually transmitted infections, etc.) that are covered in such courses, there is not enough focus on sexual issues. In addition, the options after graduation may be too advanced. Although there are numerous resources for information on sexual topics, they tend to focus on specific areas.

Thus, to adequately prepare counselors, there is a need for an advanced curriculum with a cohesive focus on sexual issues, including treatment options. Lack of
formal and informal education was cited more than any other reason for discomfort about specific sexual topics. For example, sexual dysfunctions need to be more of a focus in the education of young therapists. Results from this study suggest that this topic causes the most discomfort for therapists, although some of the other topics, such as sexual performance, sexual acting out and sexual activities of GLBT persons are not far behind. Further education on all of these topics needs to be provided so that counselors can feel more comfortable addressing these issues with their clients. This education would fill in the gap between the very general graduate Human Sexuality course and the very specific books and journal articles available for practitioners. Such training could be administered by the state as part of continuing education requirements for interns.
References


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### Appendix A:

**Literature Review Results Table**

**Table A1**: Literature Review Results.

<table>
<thead>
<tr>
<th>Study</th>
<th>Purpose</th>
<th>Population</th>
<th>Instruments</th>
<th>Outcome</th>
<th>Limitations</th>
</tr>
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<tbody>
<tr>
<td>Hays Dissertation</td>
<td>What effect does formalized sexuality education, clinical experience,</td>
<td>175 clinical AAMFT members</td>
<td>48 question survey by author, partially based on Sexuality Knowledge and</td>
<td>Certified sex therapists more likely to raise topic; sexuality education</td>
<td>Population may not include social workers or mental health professionals (unknown), only AAMFT members; ethnic breakdown of participants not</td>
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<td>(2002)*</td>
<td>positive supervisory experiences that address sexual issues, basic</td>
<td></td>
<td>Attitude Test</td>
<td>and supervisory experience best indicators of willingness, clinical</td>
<td>reported; content validity or test-retest reliability for instruments developed by author not measured; supervision questions did not</td>
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<td></td>
<td>sexual knowledge and comfort with sexual topics affect whether MFTs</td>
<td></td>
<td></td>
<td>experience has a lesser effect</td>
<td>distinguish between graduate school supervision and post graduate</td>
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<td></td>
<td>are initiating sexual topics with their clients?</td>
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<td></td>
<td></td>
<td>supervision; sample may be biased - those who are more open about sexual issues more likely to return survey</td>
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Table A1 (Continued)

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<tr>
<th>Study</th>
<th>Purpose</th>
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<th>Instruments</th>
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<tr>
<td>Harris &amp; Hays (2008)*</td>
<td>To what extent formal sexuality education, perceived sexual knowledge, and comfort with sexual topics influence whether family therapists are having sexuality discussions with their clients.</td>
<td>Same as Hays dissertation</td>
<td>Same as Hays dissertation</td>
<td>Same as Harris Dissertation, add that clinical experience influenced indirectly via perceived sexual knowledge</td>
<td>Same study as Hays dissertation</td>
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<td>Study</td>
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<td>Berman (1996) Dissertation*</td>
<td>How do a social worker's formal and informal education, sexual comfort and agency support influence willingness to address sexual issues with clients?</td>
<td>301 social workers belonging to NASW, in practice for at least one yr in an outpt mental health agency</td>
<td>Survey: 1. Agency support checklist (researcher); 2. Education experience (researcher); 3. Personal and general sexual comfort subscales of SCI; 4. Willingness to discuss clients sexual concerns subscale of the client sexual concerns checklist (Arnold, 1980)</td>
<td>No differences between males and females on sexual comfort, more in-house training for older social workers, more experienced-lower sexual items on treatment forms, and less topics in sexuality education; Informal sexuality education predicts comfort, formal education did not</td>
<td>Population was only clinical social workers; 92.4% were white non-hispanic-black then there weren't many minority social workers but this has changed; context limited to agency work, doesn't include private practice; content validity or any type of reliability not measured for author-developed instrument sexuality education experience checklist; a &quot;reliability coefficient&quot; was measured on agency support checklist- what is that supposed to mean exactly; #4 instrument not reliable, (ceiling effect) could not measure willingness properly, could not distinguish properly between willingness levels, nor what makes counselors willing;</td>
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<tr>
<td>Study</td>
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<tr>
<td>Fluharty (1995)</td>
<td>Does therapist sexual training, therapist gender and client gender affect therapists countertransference-anxiety when clients bring up sexual material?</td>
<td>75 counseling and clinical psychologists from various settings</td>
<td>Analogue study: Stroop test to establish baseline, then watched video tape of client, then: Stroop Test (measure cognitive component of distress); behavior analysis of therapist; therapists’ State Anxiety section of the State-Trait Anxiety Inventory; Sex Knowledge portion of the Sex Knowledge and Attitude Test</td>
<td>Sex of therapist was only indep variable that made a difference in therapist anxiety, with male therapists significantly less comfortable; self-perceived comfort greater in male therapists w/more training, but no differences found for females; therapists reported feeling more comfortable with the female client as opposed to the male client</td>
<td>Low power when comparisons made between subgroups; poor correlations between raters of avoidance responses, also low Kappa coefficients on total inter-rater agreement, low reliability of SKAT (coefficient alpha = .43), SKAT is an old instrument;</td>
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### Table A1 (Continued)

<table>
<thead>
<tr>
<th>Study</th>
<th>Purpose</th>
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<th>Outcome</th>
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<tr>
<td>Haag 2009 Dissertation*</td>
<td>What psychotherapist trainee characteristics predict counselor self-efficacy (CSE) in working with LGB clients or other clients on issues related to sexually variant activities</td>
<td>115 psychotherapist trainees in pre or post doctoral year in various doctoral programs</td>
<td>Modified Sexual Practices Questionnaire developed by Ford (2000)- asking about sexual values, including t (“I would feel confident...”), and comfort; Personal Attributes Questionnaire, Religious Commitment Inventory</td>
<td>CSE for sexual issues predicted by lower levels of religious fundamentalism(®=-.31, p&lt;.001), more training (®=.2, p=.03) and masculinity(®=.23, p=.02)</td>
<td>Small sample size; self-report was used to measure CSE; no validity or reliability measures performed on the SPQ; use of online survey may have eliminated some providers who don’t have access to the internet</td>
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<td>Decker 2010 Dissertation*</td>
<td>To explore the degree to which clients’ sexual issues are considered in the clinical supervision of couples/marriage therapy trainees and interns—compared demographic variables, experience variables with knowledge and comfort—i.e. what makes a supervisor more supportive?</td>
<td>103 supervisors from CAMFT-California Assn for Marriage and Family Therapists</td>
<td>Surveys developed by author</td>
<td>Participants felt knowledgeable about content areas related to sexual values or relationships, but less so when sexual issues were the predominant concern; 50% or more felt comfortable in most areas, except the unusual (i.e. fetishes, BDSM); no significant correlation between comfort and knowledge</td>
<td>Eliminated AASECT certified providers, but not graduates of other sex therapy programs—therefore sex therapists could have been included in sample; sample is only MFT and excludes other types of counselors; use of online survey may have eliminated some providers who don’t have access to the internet; participants limited to California; no reliability performed on instrument, only content validity performed–no test-retest or internal consistency measurements</td>
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<tr>
<td>Study</td>
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<tr>
<td>Ford and Hendrick 2003</td>
<td>Assessment of therapist sexual values</td>
<td>1000 practicing professional therapists members of APA or AAMFT</td>
<td>Questionnaire developed by author</td>
<td>Females more comfortable with same sex relationships; males more comfortable with non-normative sexual behavior; non-religious and to some extent Jews more comfortable with homosexuality as natural &amp; client same-sex sexual practices. Although most reported getting training they only felt “neutral” about their competence</td>
<td>Questions measuring comfort were based on the assumption that participant had adequate training, this biased the results since the participants may or may not have adequate training</td>
</tr>
<tr>
<td>Kazukauskas &amp; Lam (2010)</td>
<td>Analyze how CRC knowledge, skills, attitudes affect comfort level in addressing sexuality and disability with consumers</td>
<td>199 CRCs randomly selected from the Commission on Rehab Counselor Certification</td>
<td>Knowledge, Comfort, Approach and Attitudes toward Sexuality Scale, adapted towards people with general disability</td>
<td>Low discomfort on education or sexuality counseling; medium discomfort discovering a consumer having sex or a consumer approaching counselor in sexual manner, knowledge significantly predictive of comfort, religion or gender did not influence comfort</td>
<td>Adaptation of scale affected validity, sample homogeneous – majority white Christian and female</td>
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</table>
Table A1 (Continued)

<table>
<thead>
<tr>
<th>Study</th>
<th>Purpose</th>
<th>Population</th>
<th>Instruments</th>
<th>Outcome</th>
<th>Limitations</th>
</tr>
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</table>
| Juergens, M.H., Smedema, S. M., & Berven, N. L. (2009). | To determine factors that positively influence rehab students in initiating sexuality discussions with clients | 116 master’s students in Rehabilitation Counseling from 43 rehab programs in the U.S. (psychology students but no counseling students) | 1. Sexuality education scale developed by author  
2. Attitudes toward sexuality of ppl with disabilities (ASPDS)  
4. Counselor Willingness Scale (CWS) of the Client Sexual Concern Check List (CSCCL) (Arnold, 1980)  
5. Knowledge subscale of the Sex Knowledge and Attitudes Test–Form II (SKAT-Form II) – modified | Sexuality knowledge and comfort had direct affects on willingness; sexual education increased comfort, and sexuality knowledge improved attitudes towards disabled ppl’s sexuality, which increased comfort. |                                                                                                      |
<table>
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<tr>
<th>Study</th>
<th>Purpose</th>
<th>Population</th>
<th>Instruments</th>
<th>Outcome</th>
<th>Limitations</th>
</tr>
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<tr>
<td>Papaharitou et al. (2008)</td>
<td>To explore sexual attitudes in medical students and students in allied health professions.</td>
<td>714 1st and 4th yr college students in health professions, including psychology of two institutions in Greece</td>
<td>Participants watched a video of a client, then answered Questionnaire- 1. Info on what influenced their sexual attitudes 2. Derogatis Sexual Functioning Inventory Attitude subscale</td>
<td>Students who got information from friends, or learned behavior from media were more liberal. Students who learned information from mother were less liberal. Religious students were less liberal.</td>
<td>Population from Greece, may not be generalizable to U.S.,</td>
</tr>
<tr>
<td>Rutter et al. (2010)</td>
<td>Supervision and training aspects of two counselors in service to a transgender and lesbian couple</td>
<td>2 master’s level practicum students in a marriage and family program in the Midwest</td>
<td>Journaling prompts focused on the clinician; (qualitative-constant comparison)</td>
<td>Supervision was helpful in discussing the counselor’s worries and fears; having a co-therapist was helpful to keep things on track and having an opportunity to discuss; supervision helped b/c supervisor cared about counselor’s feelings and didn’t judge; In general, counselors felt “nervous” and not “prepared to serve this couple”</td>
<td>Cannot generalize results from such a small sample; Midwestern values tend to be more conservative- therefore results may be biased.</td>
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<tr>
<td>Study</td>
<td>Purpose</td>
<td>Population</td>
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<td>Outcome</td>
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<tr>
<td>Weerakoon et al. (2004)</td>
<td>To explore anticipated level of sexual comfort in dealing with clients' sexual issues</td>
<td>1132 undergraduate students in various health disciplines, including rehab counseling and behavioral sciences from a metropolitan university in Australia</td>
<td>Questionnaire based on Comfort Scale Questionnaire (Cohen et al., 1996)</td>
<td>More than ½ students anticipated they would not be comfortable with 9 out of 19 items; most discomfort reported about seeing client masturbate, or client making overt or covert sexual remark (and- more females reported this as a problem then men); men more comfortable dealing with lesbian client than women; women more comfortable dealing with homosexual male client than men</td>
<td>Most respondents were medical students rather than counseling students; these are students and not practitioners</td>
</tr>
<tr>
<td>Weerakoon et al. (2008)</td>
<td>Does comfort with sexuality topics improve after online course?</td>
<td>62 health professionals enrolled in an online course, Sexuality for Health Professionals</td>
<td>Same instrument as Weerakoon (2004); give pre and post course completion</td>
<td>Significant differences in comfort level for most items</td>
<td>Relied on self-report of comfort</td>
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<tr>
<td>Study</td>
<td>Purpose</td>
<td>Population</td>
<td>Instruments</td>
<td>Outcome</td>
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<tr>
<td>Arnold (1980) dissertation</td>
<td>Examine impact of counselor affective arousal caused by examination of own personal sexuality upon counselor willingness and comfort in dealing with client sexual concerns</td>
<td>68 counselors in training in Colorado, 34 treatment group and 34 in the control group. Posttest only control group design.</td>
<td>Sex Knowledge and Attitude Test, Psychology Today Sex Survey, Client Sexual Concern Check List (constructed by researcher)</td>
<td>Treatment group subjects scored significantly lower on the comfort scale of the Client Sexual Concern Check List, no differences found on the willingness scale, significant positive correlation found between knowledge scale of SKAT and willingness scale, no relationship found between completing graduate human sexuality course and liberality of sexual attitudes</td>
<td>It is stated in the abstract that subjects were “randomly assigned to either a treatment or control group,” yet there just happened to be 34 participants in each group, a highly unlikely outcome from randomization. The Client Sexual Concern Checklist was not tested on any other group other than the participants in this study. Study is OLD</td>
</tr>
<tr>
<td>Study</td>
<td>Purpose</td>
<td>Population</td>
<td>Instruments</td>
<td>Outcome</td>
<td>Limitations</td>
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<tr>
<td>Haboubi &amp; Lincoln</td>
<td>1. Views, comfort level, willingness and participation to discuss sexual issues varies by profession, age and gender? 2. Staff dealing with physically disabled adults are more comfortable with sexual issues than medical staff?</td>
<td>813 health professionals (nurses, doctors, etc. NO COUNSELORS)</td>
<td>Questionnaire developed by authors</td>
<td>Previous training poor, 90% thought it was necessary but only 62% were prepared and only 57% would encourage patients to talk about it. 68% never initiate discussions. Lack of training, lack of time and embarrassment reported as largest barriers. Male participants found to be more comfortable with topic than female</td>
<td>Study conducted on medical professionals and not counselors</td>
</tr>
</tbody>
</table>

* Indicates major studies.
Appendix B:

Text Used to Solicit Email Addresses

“I found you by googling for ‘<search term>’ (I did not use the sponsored results). I am a doctoral student working on my dissertation, and I was wondering if I could have your email address to send you a link to a survey within the next few months. Thank you very much,

Barbara LoFrisco”
Appendix C:

Sexual Issues Survey

Introduction
This survey is divided into three parts. The first part will collect demographic information. The second part focuses on your current practice as a clinician and the third part focuses on your experiences in supervision. Parts two and three address sexual issues in counseling. This survey will take approximately 15 – 20 minutes to complete. Your participation is most appreciated.

For this survey, a sexual issue is defined as any sexual concern a client or couple may have. Examples include sexual dysfunction, lack of physical intimacy, and sexually compulsive behaviors.

Part I. Demographic Information

1. I am currently practicing psychotherapy and/or counseling:
   a. Yes
   b. No (They will be thanked and exited from survey)

2. Please list your credentials: (Choose all that apply)
   a. Licensed mental health counselor
   b. Registered mental health counselor intern
   c. Licensed marriage and family therapist
   d. Registered marriage and family therapist intern
   e. Licensed clinical social worker
   f. Registered clinical social worker intern
   g. Psychologist
   h. Psychologist intern
   i. Sex Therapist
   j. Other (Please specify):____________________

3. Please indicate your gender:
   a. Female
   b. Male
   c. Other

4. Please indicate your ethnicity:
   a. Caucasian
b. African American
c. Hispanic
d. Asian American
e. Native American
f. Other (Please specify):______________________

5. I consider my religious affiliation to be:
   a. Catholic
   b. Protestant
   c. Jewish
   d. Other (Please specify): ____________________________.

6. Which of the following best describes your religious beliefs?
   a. I follow my religion very seriously
   b. I follow my religion somewhat seriously
   c. I consider myself mostly spiritual and don’t really follow a particular religion
   d. I consider myself agnostic
   e. I consider myself atheist

Part II. Current Practice
The questions in this section refer to addressing your clients’ sexual issues in a counseling setting.

7. Some counselors have difficulty addressing sexual issues for a variety of reasons. How comfortable are you with addressing clients’ sexual issues? (Choose the answer that most closely applies to you)
   a. Very comfortable
   b. Somewhat comfortable
   c. Comfortable about half the time
   d. Somewhat uncomfortable
   e. Very uncomfortable

8. Considering your caseload of individual clients as a whole, what percentage of the time have you initiated a conversation about sexual issues? (Choose the answer that most closely applies to you)
   a. N/A - I don’t see individuals
   b. In at least half of the cases
   c. In about a quarter of the cases
   d. In about 10% of the cases
   e. Never

9. Considering your caseload of couples clients as a whole, what percentage of the time have you initiated a conversation about sexual issues? (Choose the answer that most closely applies to you)
   a. N/A - I don’t see couples
   b. In at least half of the cases
c. In about a quarter of the cases
d. In about 10% of the cases
e. Never

10. What do you do when a client raises a sexual issue about which you are familiar? (Choose all that apply)
   a. I discuss it
   b. I refer out to an appropriate resource
   c. Ignore it, or tell the client I do not address issues in this domain
   d. Other (please specify):

11. Where do you refer clients with sexual issues? (Choose all that apply)
   a. A Sex Therapist
   b. Another therapist with experience with sexual issues
   Other (please specify):

12. What do you do when a client raises a sexual issue beyond your knowledge or comfort level? (Choose all that apply)
   a. Address their issue, consulting with experts as necessary (skip to #13)
   b. Give minimal information and change the topic (skip to #13)
   c. Tell them you aren’t sure how to address this and you need to research it (skip to #13)
   d. Tell them you aren’t sure how to address this and refer them to an appropriate resource
   e. Ignore it, or tell the client I do not address issues in this domain (skip to #13)
   f. Other (please specify):

13. How do you determine when sexual issues are beyond your comfort level? (Choose all that apply)
   a. When I begin to feel embarrassed about the topic
   b. When I do not have the required knowledge
   c. When I do not have sufficient experience
   d. Other (please specify):

Questions 14 through 19:

Comfort with sexual issues can vary widely based on the types of issues. In the next section, each question will represent a sexual topic. For each topic, a matrix will be provided with the rows composed of possible reasons, and the columns with intensity levels. For each topic, if you feel discomfort, please indicate any possible reasons, including the severity of the reason(s), by selecting the appropriate column in the appropriate row.
For example, if you typically experience “slight” discomfort with the topic of sexual performance because you lack knowledge about this topic, for question 14 you would select the option “slight” in the “lack of knowledge” row.

<table>
<thead>
<tr>
<th>14. Sexual Performance</th>
<th>Slight</th>
<th>Moderate</th>
<th>Substantial</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Lack of formal/Informal education</td>
<td>______</td>
<td>______</td>
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<tr>
<td>b. Lack of experience</td>
<td>______</td>
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<tr>
<td>c. Lack of access to Information</td>
<td>______</td>
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<tr>
<td>d. Personal embarrassment</td>
<td>______</td>
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<tr>
<td>e. My religious beliefs</td>
<td>______</td>
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<tr>
<td>f. Beyond my scope of practice</td>
<td>______</td>
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<td>g. Other</td>
<td>______________________</td>
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<thead>
<tr>
<th>15. Sexual Dysfunctions</th>
<th>Slight</th>
<th>Moderate</th>
<th>Substantial</th>
</tr>
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<tbody>
<tr>
<td>a. Lack of formal/Informal education</td>
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<td>______</td>
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<tr>
<td>b. Lack of experience</td>
<td>______</td>
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<tr>
<td>c. Lack of access to Information</td>
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<tr>
<td>d. Personal embarrassment</td>
<td>______</td>
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<td>e. My religious beliefs</td>
<td>______</td>
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<tr>
<td>f. Beyond my scope of practice</td>
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<td>g. Other</td>
<td>______________________</td>
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<table>
<thead>
<tr>
<th>16. Sexual Acting Out</th>
<th>Slight</th>
<th>Moderate</th>
<th>Substantial</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Lack of formal/Informal education</td>
<td>______</td>
<td>______</td>
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<tr>
<td>b. Lack of experience</td>
<td>______</td>
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<tr>
<td>c. Lack of access to Information</td>
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<tr>
<td>d. Personal embarrassment</td>
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<tr>
<td>e. My religious beliefs</td>
<td>______</td>
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<tr>
<td>f. Beyond my scope of practice</td>
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<tr>
<td>g. Other</td>
<td>______________________</td>
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<thead>
<tr>
<th>17. Sexual Activities of GLBT Persons</th>
<th>Slight</th>
<th>Moderate</th>
<th>Substantial</th>
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</thead>
<tbody>
<tr>
<td>a. Lack of formal/Informal education</td>
<td>______</td>
<td>______</td>
<td>______</td>
</tr>
<tr>
<td>b. Lack of experience</td>
<td>______</td>
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<tr>
<td>c. Lack of access to Information</td>
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<td>d. Personal embarrassment</td>
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<tr>
<td>e. My religious beliefs</td>
<td>______</td>
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<td>______</td>
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<tr>
<td>f. Beyond my scope of practice</td>
<td>______</td>
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</table>
18. Sexual Abuse (Survivors)  
   Slight  Moderate  Substantial  
   a. Lack of formal/Informal education  
   b. Lack of experience  
   c. Lack of access to Information  
   d. Personal embarrassment  
   e. My religious beliefs  
   f. Beyond my scope of practice  
   g. Other _______________________

19. Other - Please specify any other sexual topics that cause discomfort, along with the possible reason and severity similarly as you have answered for questions 13–18. For example, if you feel substantial discomfort with discussing gender issues due to a lack of resources, you would indicate “Gender issues, lack of resources, substantial”

There are many reasons why counselors may be reluctant to address sexual issues with clients. For each, select “true”, “false,” or “not sure.” If you select “true” or “not sure”, please state why.

20. Clients’ sexual issues are not appropriate for therapy (TRUE or FALSE or NOT SURE)

21. Please explain why you think clients sexual issues are or are not appropriate for therapy: ______________________

22. I am not comfortable discussing clients’ sexual issues with the opposite gender as compared with same gender (TRUE or FALSE or NOT SURE)

23. Please explain why you are or are not comfortable discussing clients’ sexual issues with the opposite gender as compared with the same gender: ______________________

24. Other inhibitors that affected my ability to address clients’ sexual issues. Please include an explanation. ______________________

Part III. Postgraduate Supervisory Experiences

25. Please indicate how many years have passed since you have received clinical supervision as an intern (Choose one):
   a. 0 – 5 years  
   b. 5 – 10 years  

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c. 10 – 15 years (they will be thanked and exited from survey)
d. 15 – 20 years (they will be thanked and exited from survey)
e. Over 20 years (they will be thanked and exited from survey)

26. Did your supervisor provide support in addressing your client’s sexual issues?
   a. Yes (Skip to 30)
   b. None or minimal

27. My supervisor provided little or no support in addressing my clients’ sexual issues because:
   a. I didn’t ask my supervisor about those kind of issues
   b. I asked, but my supervisor was not responsive (Skip to question #29)
   c. Other (Please specify) ________________________________

28. I didn’t ask my supervisor about my clients’ sexual issues because: (Choose all that apply)
   a. I wasn’t comfortable with the topic of sexual issues
   b. I didn’t think the topic was appropriate for supervision
   c. I didn’t have any clients with sexual issues
   d. The topic was never part of my practice
   e. I didn’t think my supervisor had enough knowledge or experience
   f. I thought my supervisor wasn’t comfortable with the topic
   g. The supervisory environment did not feel safe to me
   h. Other (Please specify) ________________________________

29. Please select the ways in which clinical supervisors should provide support to counselors in addressing clients’ sexual issues. Select all that apply, then rank their importance using the following scale:

   1 – Most important; 2 – Somewhat important, 3 – Neutral, 4 – Somewhat unimportant, 5 – Least important

   My supervisor:     Most          Least
                      Important      Important

   a. Indicated that clients’ sexual issues were an appropriate topic for supervision
      1  2  3  4  5

   b. Provided educational materials/instruction on sexual issues
      1  2  3  4  5

   c. Discussed my comfort level in addressing sexual issues
      1  2  3  4  5

   d. Helped me to process my own internalized views relative to sexuality
      1  2  3  4  5

   e. Other - Please specify any other ways in which your supervisor was supportive, and its importance to you at the time. ____________________
End of Survey

Thank you for your participation
Appendix D:
Decision Tree for Survey

Q 7. How comfortable are you in addressing clients’ sexual issues.

Q 8/9. What percentage of the time have you asked about clients’ sexual issues?

Q 10. What do you do when a client raises a sexual issue about which you are familiar?

Q 11. What do you do when a client raises a sexual issue beyond your knowledge or comfort level?

Attempt to address it
Change the topic
Research it
Ignore it

Refer them elsewhere

Q 12. Where do you refer clients with sexual issues?
Q 13. How do you determine when sexual issues are beyond your comfort level?

Q 14 - 19. Questions about discomfort with various sexual topics

Q 20 - 24. Questions about specific causes of discomfort

Q 25. Please indicate how many years have passed since you've had clinical supervision.

Less than 10 years

10 years or more - exit survey

Q 26. Did your supervisor provide support in addressing your clients' sexual issues?

Yes

No

Q 27. If your supervisor was not supportive, please select all that apply

Other

I asked, but supervisor not supportive

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Q28. I didn’t ask my supervisor about my clients’ sexual issues because:

Q29. In what ways should supervisors support their supervisees in addressing their clients’ sexual issues?
Appendix E:

Sexual Issues Survey With Probes

Introduction
As you are taking this survey, I am going to ask you about your thought process, so I will be asking you questions after every question you answer. If at any time you do not understand a question, or struggle choosing an option, please let me know. I would also appreciate hearing any thoughts you may have as you answer the questions.

This survey is divided into three parts. The first part will collect demographic information. The second part focuses on your current practice as a clinician and the third part focuses on your experiences in supervision. Part two and three address sexual issues in counseling. This survey will take approximately 7-10 minutes to complete. Your participation is most appreciated.

Part I. Demographic Information
1. Please provide your qualifications: (Choose all that apply)
   a. Licensed mental health counselor
   b. Registered mental health counselor intern
   c. Licensed marriage and family therapist
   d. Registered marriage and family therapist intern
   e. Licensed clinical social worker
   f. Registered clinical social worker intern
   g. Psychologist
   h. Psychologist intern
   i. Sex Therapist (they will be thanked and exited from survey)
   j. Other (please specify):____________________

Probe: a) Do you fall within one of these categories?

2. I am currently practicing psychotherapy:
   a. Yes
   b. No (they will be thanked and exited from survey)

Probe: a) What did this question mean to you?
   b) Were the choices ambiguous?

3. Please indicate your gender:
   a. Female
   b. Male
4. Which of the following best describes your religious practice?
   a. I am very involved in religious activities
   b. I attend religious activities sometimes
   c. I attend religious activities on religious holidays
   d. I consider myself spiritual, I do not follow a particular dogma
   e. I consider myself agnostic
   f. I consider myself atheist

_Probe:_
   a) Can you repeat this question in your own words?
   b) What thoughts or feelings do you have about answering this question?

5. I consider my religious affiliation to be _____________________.

_Probe:_
   a) Were you able to easily come up with an answer?

Part II. Current Practice
The questions in this section refer to addressing your clients’ sexual issues in a counseling setting.

6. What do you do when a client raises a sexual issue beyond your comfort level?
   (Choose the answer that most closely applies to you)
   a. Refer them elsewhere
   b. Tell them you aren’t sure how to address this and you need to research it (skip to #8)
   c. Give minimal information and change the topic (skip to #8)
   d. Address their issue (skip to #8)
   e. Other (please specify): _______________________________ (skip to #8)

_Probes:_
   a) What does “Sexual issue” mean to you?
   b) What feelings do you have as you answer this question?
   b) How hard is it to remember this information?
   c) Was it difficult to choose between the options?
   d) How sure are you of your answer?
7. Where do you refer clients with sexual issues? (Choose the answer that most closely applies to you)
   a. A Sex Therapist  
   b. Another therapist with experience with sexual issues  
   c. Other (please specify): __________________________

Probes: a) What, to you, is a “Sex Therapist”?
   b) How difficult was it to remember this information?
   c) What does “experience with sexual issues” mean to you?
   d) How do you know the therapist is experienced in sexual issues?
   e) What is the difference between a Sex Therapist and a therapist experienced in sexual issues?

8. How do you determine when sexual issues are beyond your comfort level?
   __________________________

Probes: a) What feelings did you have as you answered this question?
   b) Was this question hard to answer?
   c) How much have you thought about when to refer clients?

9. How comfortable are you with addressing clients’ sexual issues? (Choose the answer that most closely applies to you)
   a. Very comfortable 
   b. Somewhat comfortable 
   c. Somewhat uncomfortable 
   d. Very uncomfortable

Probes: a) What, to you, does “addressing clients’ sexual issues” mean?
   b) What, to you, does “comfortable” mean?
   c) What feelings do you have as you answer this question?
   d) Was it difficult to choose your answer?

10. Out of the following possible sexual topics to address with clients, please select all that make you feel uncomfortable and state why.
    a. Pedophilia because __________________________
b. Sexual predators because ______________________

c. Sexual acting out because _______________________ 

d. Sexual activities of GLBT persons because ______________________

e. Other (please specify)_________________ because ______________________

f. There are no specific sexual issues that cause me discomfort

Probes: a) What feelings do you have as you answer this question?

b) What does the term “sexual predators” mean to you?

c) What does the term “sexual acting out” mean to you?

d) What does the term “GLBT” mean to you?

e) Was it difficult for you to answer this question?

f) How much thought have you given to these topics?

11. How often do you ask clients about their sexual issues in their individual sessions? (Choose the answer that most closely applies to you)
   a. Often (skip to section III)
   b. Occasionally (skip to section III)
   c. Seldom
   d. Never

Probes: a) What feelings do you have as you answer this question?

b) What thoughts do you have as you answer this question?

c) How did you choose your answer?

12. How often do you ask clients about their sexual issues in their couples’ sessions? (Choose the answer that most closely applies to you)
   a. Often (skip to section III)
   b. Occasionally (skip to section III)
   c. Seldom
   d. Never

Probes: a) What feelings do you have as you answer this question?

b) What thoughts do you have as you answer this question?

c) How did you choose your answer?
For each, select true or false. If you select true, please state why.

13. Clients' sexual issues are not appropriate for therapy (TRUE or FALSE)
Probes: a) What does “not appropriate for therapy” mean to you?

14. If you selected TRUE, please state why:________________________
Probes: a) What feelings do you have as you answer this question?
   
   b) Was it difficult for you to come up with a reason?

15. I have little knowledge about addressing sexual issues with clients (TRUE or FALSE)
Probes: a) What does “little knowledge” mean to you?

16. If you selected TRUE, please state why:________________________
Probes: a) What feelings do you have as you answer this question?
   
   b) Was it difficult for you to come up with a reason?

17. My religious beliefs inhibit my ability to address clients’ sexual issues (TRUE or FALSE)
Probes: a) What do “religious beliefs” mean to you?
   
   b) What feelings do you have as you answer this question?
   
   c) What thoughts do you have as you answer this question?

18. If you selected TRUE, please state why:________________________
Probes: a) What feelings do you have as you answer this question?
   
   b) Was it difficult for you to come up with a reason?

19. I am not comfortable discussing clients’ sexual issues with the opposite gender (TRUE or FALSE)
Probes: a) What feelings do you have as you answer this question?

20. If you selected TRUE, please state why:________________________
Probes: a) What feelings do you have as you answer this question?

b) Was it difficult for you to come up with a reason?

21. Other inhibitors that affected my ability to address clients’ sexual issues:

_______________________________

22. If you’ve included items for #21, please state why:______________________

Probes: a) Was it difficult for you to think of other inhibitors?

b) What feelings did you have as you tried to think of other inhibitors?

Part III. Postgraduate Supervisory Experiences

23. Please select the ways in which your supervisor provided support in addressing your clients’ sexual issues, and then rank importance with rating of:

1 – Most important; 2 – Somewhat important, 3 – Neutral, 4 – Somewhat unimportant, 5 – Least important (then skip to question #26)

a. Provided instruction on appropriate topics for supervision 1 2 3 4 5

b. Provided educational materials/instruction on sexual issues 1 2 3 4 5

c. Discussed your comfort level in addressing sexual issues 1 2 3 4 5

d. Helped you to process your own internalized views relative to sexuality 1 2 3 4 5

e. Asked about how your religious orientation influenced your perspectives regarding sexuality 1 2 3 4 5

f. My supervisor provided no support in this area

g. Other (please specify)_______________________________________

Probes: a) What, to you, does “providing support” mean?

b) Did you have trouble understanding what each item meant?

c) Was it difficult for you to rank importance on any item? If so, why?

d) What feelings do you have as you are answering this question?

e) Did you have trouble recalling this information?
f) How sure are you of your answer?

24. If your supervisor provided no support in addressing your clients' sexual issues was it because: (Choose all that apply)
   d. I didn’t ask my supervisor about those kind of issues
   e. I asked, but my supervisor was not supportive (Skip to question #26)
   f. Other (Please specify)____________________________________

Probes: a) What feelings do you have as you answer this question?

   b) What thoughts do you have as you answer this question?

   c) How well do you remember this information?

   d) How sure are you of your answer?

25. I didn’t ask my supervisor about my clients’ sexual issues because: (Choose all that apply)
   a. I wasn’t comfortable with the topic
   b. I didn’t think the topic was appropriate for supervision
   c. I didn’t have any clients with sexual issues
   d. The topic was never part of my practice
   e. I didn’t think my supervisor had enough knowledge or experience
   f. I thought my supervisor wasn’t comfortable with the topic
   g. The supervisory environment did not feel safe to me
   h. Other (Please specify)____________________________________

Probes: a) What feelings do you have as you answer this question?

   b) How difficult was it to match your thinking to these items?

   c) How well do you remember this information?

   d) How sure are you of your answer?

26. In what ways should supervisors support their supervisees in addressing their clients’ sexual issues? (Choose all that apply)
   a. Provide instruction in appropriate topics for supervision
   b. Provide educational materials/instruction on sexual issues
   c. Discuss supervisees’ comfort level in addressing sexual issues
   d. Help supervisees to process own internalized views relative to sexuality
   e. Ask about how supervisees’ religious orientation influenced their perspectives regarding sexuality
   f. Other (Please specify)____________________________________
Appendix F:

Survey Initial Notice Verbiage

Hello,

My name is Barbara LoFrisco and I am a doctoral student working on my dissertation at the University of South Florida. Research shows that many clients have sexual issues, but they aren’t always getting addressed in therapy. Thus, I am working on important research to benefit our profession: how counselors are addressing clients’ sexual issues, how comfortable they feel, and what clinical supervisors can do to help. This research has been approved by the IRB (#12831).

If you choose to participate, you will have the option to enter a raffle for a $50 Amazon.com gift certificate.

I am asking for your help, because you are a mental health professional with an online presence. Your email address was found by doing an online search for mental health professionals in the area, or perhaps you are a member of the Tampa Bay Association for Marriage and Family Therapy, who has been kind enough to forward this survey to its members. Your participation is vital because the only way I can get this type of information is through professionals like yourself. This survey will take approximately 15 or 20 minutes of your time, and anonymity is assured. I appreciate your consideration, and I thank you in advance for participating in my study. We have an opportunity to advance and improve our profession, but I’ll need your participation to do so.

If you have any questions about the survey, or require assistance in its completion, I can be reached at (813) 404-9215.

Sincerely,

Barbara LoFrisco
Doctoral Candidate, University of South Florida
Appendix G:

Survey Follow-up Verbiage

Hello,

My name is Barbara LoFrisco and I am a doctoral student working on my dissertation at the University of South Florida. Two weeks ago I sent out an email with a link to a survey that explores how counselors are addressing sexual issues. To protect the anonymity of my participants, I do not track who has responded, so if you have already responded to this survey kindly disregard this reminder.

If you choose to participate, you will have the option to enter a raffle for a $50 Amazon.com gift certificate. If you have previously participated but were unable to enter the raffle, you may enter the raffle by participating again. In order to do this, please be sure to either clear the cache on your browser or use a different one. Please note that the last day to participate in this survey is June 13.

Many people have already responded to this survey and have provided valuable information about what has helped them address clients’ sexual issues. These responses are very useful in my research, which has been approved by the IRB (#12831).

I am writing again to ask for your help. You have been selected because you are a mental health professional with an online presence. Your participation is vital because the only way I can get this type of information is through professionals like yourself. This survey will take approximately 15 or 20 minutes of your time, and anonymity is assured. Again, I thank you in advance for your participation.

If you have any questions about the survey, or require assistance in its completion, I can be reached at (813) 404-9215.

Sincerely,

Barbara LoFrisco
Doctoral Candidate, University of South Florida
Appendix H:

Initial IRB Approval

5/10/2013

Barbara LoFrisco, M.A.
Psychological and Social Foundations
4202 East Fowler Ave., EDU 380
Tampa, FL 33620

RE: Exempt Certification
IRB#: Re00012831
Title: Counselor Discomfort With Sexual Issues and Supervisory Role
Study Approval Period: 5/10/2013 to 5/10/2018

Approved Items:
Protocol Document:
V1.050613 LoFrisco Proposal.docx
Consent Script:
V1.050613 Informed Consent.docx

Dear Ms. LoFrisco:

On 5/10/2013, the Institutional Review Board (IRB) determined that your research meets USF requirements and Federal Exemption criteria as outlined in the federal regulations at 45CFR46.101(b):

(2) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless:
(i) information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and (ii) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

As the principal investigator for this study, it is your responsibility to ensure that this research is conducted as outlined in your application and consistent with the ethical principles outlined in the Belmont Report and with USF IRB policies and procedures. Please note that changes to this protocol may disqualify it from exempt status. Please note that you are responsible for notifying the IRB prior to implementing any changes to the currently approved protocol.

The Institutional Review Board will maintain your exemption application for a period of five
years from the date of this letter or for three years after a Final Progress Report is received, whichever is longer. If you wish to continue this protocol beyond five years, you will need to submit a new application at least 60 days prior to the end of your exemption approval period. Should you complete this study prior to the end of the five-year period, you must submit a request to close the study.

We appreciate your dedication to the ethical conduct of human subject research at the University of South Florida and your continued commitment to human research protections. If you have any questions regarding this matter, please call 813-974-5638.

Sincerely,

John Schinka, Ph.D., Chairperson
USF Institutional Review Board
Appendix I:

IRB Amendment Approval

RE: Expedited Approval for Amendment
IRB#: Amel_Pro00012831
Title: Counselor Discomfort With Sexual Issues and Supervisory Role

Dear Ms. LoFrisco:

On 5/23/2013, the Institutional Review Board (IRB) reviewed and APPROVED your Amendment. The submitted request has been approved for the following:

1. Change in recruitment:
   (A) Participants who had previously participated but were unable to enter the raffle may enter the raffle by participating again. After sending the initial recruitment email with the survey link, it was discovered that the sweepstakes for a $50 Amazon.com gift certificate had not been added to the survey. This was immediately corrected, and verbiage was included in the follow-up email instructing those who had not had the opportunity to participate in the sweepstakes to re-enter the survey by first clearing their browser cache or using a different one.
   (B) Revised Survey Follow Up email

2. Revised protocol, v2.052113

Approved Item(s):
Protocol Document(s):
V2.052113 LoFrisco Proposal.docx

We appreciate your dedication to the ethical conduct of human subject research at the University of South Florida and your continued commitment to human research protections. If you have any questions regarding this matter, please call 813-974-5638.

Sincerely,

John Schinka, Ph.D., Chairperson
USF Institutional Review Board
About The Author

Barbara M. LoFrisco received her bachelor’s degree in Computer Science from the State University of New York College of Technology; her master’s in Rehabilitation and Mental Health Counseling from the University of South Florida; and has completed doctoral coursework in Counselor Education and Supervision also at the University of South Florida. She is a licensed mental health counselor, a licensed marriage and family therapist and a certified sex therapist in private practice in Tampa, FL. She maintains a dual professional identity by membership in professional counseling organizations both at the national and local level. She has served as an Election Committee member for the Tampa Bay Association for Marriage and Family Therapy, as well as assisting the National Board for Certified Counselors in updating their Distance Professionals Service policy. She has also published articles in the Career Planning and Adult Development Journal, the Journal of Sex Research and the Career Development Quarterly. She has also published several non-refereed articles, including writing as a paid blogger for Best Online Universities. She also has made several radio appearances as a local expert on sexuality and relationships. For more information, please visit her Teaching Portfolio, http://barbaramlofrisco.com, or her clinical practice website, http://www.counselorbarb.com.