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Counselors' Comfort Levels and Willingness to Discuss Sexual Issues with Couples They Counsel

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Counselors' Comfort Levels and Willingness to Discuss Sexual Issues with Couples They
Counsel

A Dissertation

Submitted to the Graduate Faculty of the
University of New Orleans
in partial fulfillment of the
requirements for the degree of

Doctor of Philosophy
in
Counselor Education

By

Rachel Wieck Cupit

B.A., Loyola University New Orleans, 2004
M.A., Our Lady of Holy Cross College, 2007

May 2010

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Dedication

I dedicate this dissertation to my husband, Andy. Without your love, encouragement, and support I don't think I would have been able to accomplish all that I have. You make each day better and brighter. You help make me be a better counselor, friend, wife, and person. I love you so very much and always will.

I also dedicate this dissertation to my parents and siblings. Dad, you have always said I can do whatever I want as long as I put my mind to it. This gave me the confidence to continue to strive for excellence. Mom, you are the most empathic person I know and have taught me to understand others and love unconditionally. Crissy, you have shown me strength, perseverance, generosity and genuineness. Paul, you have taught me sensitivity, kindness, and love. You all have given me so much that helped me learn and grow as a counselor. I love you and am eternally grateful for everything you have given me.

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Abstract

The purpose of this study was to examine the factors that influence the relationship between counselors' sexual comfort and their willingness to discuss sexual issues with the couples they counsel. I surveyed 2000 members of the American Counseling Association (ACA). This study examined the relationships between counselors' sexual comfort and their willingness to discuss sexual issues with couples with a variety of variables. The results revealed that counselors' sexual education and training experience, supervision experience discussing sexuality, sexual attitudes, and age were all associated with both counselors' sexual comfort and willingness to discuss sexual issues with couples. Counselors' years of practice was found to be associated with their sexual comfort. Types of graduate specialization were found to be associated with counselors' willingness to discuss sexual issues with couples. The results of this study have implications for counselors, counselor educators, and supervisors. My hope is that counselor educators will utilize this knowledge to address counselors' in training sexual comfort level and willingness to discuss sexual issues with the couples.

Keywords: counselor, couples counseling, sexuality, sexual attitudes, sexuality education, sexuality training, sexual knowledge, sexual comfort, willingness to discuss sexuality

CHAPTER ONE

Introduction

Openly discussing sexuality and issues surrounding sexuality can be very helpful for individuals in a variety of personal and professional settings. In a romantic relationship, communicating openly about the sexual relationship helps to facilitate an overall healthy relationship (Cross, 1991; Guldner & Guldner, 1992; Meisel, 1977). Open communication about the sexual relationship often can be a struggle for couples, and research shows that many couples who encounter difficulties in their relationship often have underlying sexual issues that need to be explored (Guldner & Guldner, 1992). Couples in this predicament frequently seek counseling to work through some of their issues. In counseling, couples often consider the counselor to be an expert on many topics, including sexuality; therefore, they expect to find support and guidance on sexual issues (Nathan, 1986). However, counselors are only human, and some may find it just as difficult as their clients to discuss sexual issues (Guldner & Guldner, 1992; Haboubi & Lincoln, 2003). Though counselors are trained to discuss difficult issues with clients, they may not feel completely comfortable discussing a variety of sensitive issues, including sexuality (Anderson, 2002; Haboubi & Lincoln, 2003; Weerakoon & Stiernborg, 1996). Therefore, I explored factors that influence counselors' sexual comfort and willingness to discuss sexual issues with couples they are counseling.

The Problem in Perspective

Sex is an especially important aspect in a marriage because of its influence on overall marital satisfaction (Byers, 2005; Donnelly, Guo & Huang, 2005; Hatfield, Greenberger, Traupmann, & Lambert, 1982; McCabe, 1999; 1993; Sprenger, 1998; 2002). Therefore, directly addressing sexual issues with clients is important for couples' counselors. If counselors avoid discussing these issues, they run the risk of stifling client growth, both for clients as individuals

and as a couple (Hilton, 1997). Still, many counselors fail to directly address sexuality and sexual issues with the couples they counsel (Haboubi & Lincoln, 2003; Harris & Hays, 2008). There is very little empirical data regarding the extent to which counselors discuss sexuality and sexual issues with their clients, and some researchers believe it is an essentially unaddressed issue in therapy (Harris & Hays, 2008). Harris and Hays (2008) speculated that this is due to the fact that counselors often receive little to no training on how to address sensitive issues such as sexuality in clinical settings. I suspected that one explanation for why some counselors are not discussing sexuality and sexual issues with couples may be due to counselors' low levels of sexual comfort.

Graham and Smith (1984) conducted a study to develop a definition of sexual comfort. They surveyed sex educators, and the following definition was developed based on the results: "Sexual comfort is a broad, complex construct involving cognitive, affective, and behavioral responses to sexuality; as well as a developmental task influenced by the physiological, psychological, sociological, spiritual or religious, educational, and sexual aspects of one's being" (Graham & Smith, 1984, p.439). For the purpose of this study, I will be using the operation definition of sexual comfort as defined by Graham and Smith. Counselors' sexual comfort may be influenced by their sexual attitudes, their training and experience in discussing sexual issues in professional settings, sexual knowledge, supervision experience addressing sexuality, and/or clinical experience with couples with sexual issues (Anderson, 2002; Harris & Hays 2008; Hedgepeth, 1988).

Conceptual Framework

In creating a conceptual framework for this study, I chose to focus on the work of Carl Rogers and his person-centered theory. According to Rogers (1951), the goal of person-centered therapy is to create an environment that enables clients to work towards self-actualization.

Counselors work to create an environment that promotes safety and trust (Corey, 2005; Rogers, 1951). Counselors who directly discuss sexuality with their clients help to foster this type of environment (Wicks, Parsons, & Capps, 1993). Counselors can create a safe place for clients that encourages growth if they have healthy attitudes and beliefs about the topic that is being discussed (Corey, 2005; Rogers, 1951). According to Rogers, counselors are able to create a therapeutic relationship that allows clients to feel safe expressing their feelings and attitudes. Clients can express themselves without feelings of guilt and/or shame or worrying their counselors will not understand their feelings. This is echoed in the work of Raskin and Rogers (2000) in their discussion of self-exploration. Through exploration, clients are able to gain a better understanding of their behaviors. The desires and behaviors expressed by clients, some of which may be associated with feelings of guilt or shame, are received with warmth and respect by the counselor. In return, clients learn to accept themselves as the counselor accepts them. Clients should experience total acceptance and should know that they have the freedom to express themselves without feeling shamed or judged by the counselor. The safe environment created by the counselor allows clients to speak openly, honestly, and directly about concerns that they might not be able to discuss openly with anyone else (Raskin & Rogers, 2000; Rogers, 1951).

Rogers (1977) believed that the purpose of therapy is not to fix clients' problems. Instead, the counselor should help clients to grow and work towards self-actualization so that they might be more equipped to handle their own problems in the future without the assistance of the counselor (Rogers, 1977). In Roger's (1961) earlier writings he explores how counselors should observe the following characteristics in their clients as they grow and become more self-actualized: increased trust in themselves, openness to new experiences, self-evaluation, and a

desire to continue learning and growing (Rogers, 1961). Rogers later found that research supported his theory. Research has shown that the relationship a client builds with a counselor provides the greatest possibility for change in the client (Raskin & Rogers, 2000). Because the counselor-client relationship is so important, it is the counselor's responsibility to create a safe environment. Because a counselor's own attitudes and beliefs so greatly affect this environment, it seems rather important that the counselor be self-actualizing, as well (Andrews, 2000; Rogers, 1951).

According to Abraham Maslow (1965) self-actualization is occurring when an individual is "experiencing fully, vividly, selflessly, with full concentration and total absorption" (p.111). Many in the counseling field have commented on the importance for counselors of achieving this sense of personal comfort within their own lives as they themselves are affected by sensitive topics such as sexuality (Anderson, 2002; Masters & Johnson, 1970; Weerakoon & Stiernborg, 1996).

Counselors may have had extensive training in human sexuality but will still have their own very personal and emotional reactions to issues involving sex (Anderson, 2002). This may lead to problems because, according to Seligman (2004), it is important for counselors to remain neutral and avoid imposing their own values and beliefs on clients, but it cannot be ignored that counselors have their own personal feelings and reactions to their clients and their clients' issues. Counselors must be comfortable with their own sexuality and achieve self-actualization in regards to their own personal issues about sex and sexual relationships in order to best serve their clients. Sexuality should not be neglected in the process of self-actualization, and counselors must realize its importance in a client's journey towards self-actualization, as well as in their own.

Counselors are influenced by their own personal experiences. Countertransference is the term often used to describe reactions within the clinical setting that counselors may experience based on their own issues (Rogers, 1951; Seligman, 2004). Counselors' reactions are influenced much more by their own issues than by the behaviors of their clients. It is important for counselors to pay attention to these reactions, and if the reactions have the potential to hinder the counseling relationship in any way, it is necessary for counselors to seek supervision concerning these reactions, as they can interfere with the therapeutic process (Rogers, 1951; Seligman, 2004). Person-centered counselors must remember to stay focused on the client's feelings, thoughts, attitudes, and behaviors when they find themselves thinking about their own and counselors should work through their own issues with any given topic in supervision or with their own personal counselors (Rogers, 1951). Specifically regarding sexuality, if counselors work to improve their own comfort levels, they will be better able to serve their clients. Counselors who convey a sense of comfort with sex and sexuality by speaking openly and honestly with clients create an environment within which the client feels safe to discuss issues related to sex (Wicks et al., 1993).

Self-exploration is a very important part of counselor training and should continue throughout a counselor's career (Corey, 2005). Sexuality is one of the many areas that should be explored so that counselors can better serve their clients, according to Corey (2005). A research study that examined marriage and family counselors' sexual comfort level found that the higher counselors' levels of sexual comfort, the more likely counselors were to engage in discussions about sex with their clients (Harris & Hays, 2008). This is an example of how counselors' sexual comfort can impact the therapeutic relationship, which emphasizes how important it is for counselors to examine their own sexuality.

If counselors are uncomfortable with their own sexuality, they will be ineffective and potentially harmful in attempting to help others examine their sexuality (Masters & Johnson, 1970). Counselors generally hope to serve their clients to the best of their ability, and sometimes this requires them to move outside their own comfort zones and work to become more comfortable with their own sexuality. Wicks et al. (1993) found that, in general, clients appreciate working with counselors who are direct and clear in their questions and inquiries about the clients' sexual behavior. Counselors who avoid specifics concerning sexual behaviors or sexual problems run the risk of isolating their clients. Avoiding clients' real sexual issues may lead clients to believe that their behavior is deviant or wrong, causing the client to feel alienated. On the other hand, the topic of sex may be difficult for clients to discuss. It is important for counselors to be sensitive to clients' anxiety. When discussing sexual issues, counselors may want to begin by discussing issues that are less personal in nature, and proceed according to the client's comfort level (Wicks et al., 1993). This will help create a safe place in which clients can explore their sexual concerns.

Because sex is often considered to be a taboo topic, counselors cannot assume that their clients will initiate the discussion of sexual concerns. If the counselor never initiates a sexual discussion, the client may assume that sex is not an appropriate topic to be discussed in session, and the client may never have the opportunity to explore this important issue. This could be detrimental to the counseling relationship (White & DeBlassie, 1992). In couples counseling, the couple usually expects the counselor to create a safe environment that helps to facilitate the exploration of challenging problems (Estrada & Holmes, 1999). If the counselor initiates a sexual discussion, the couple will feel more comfortable and more willing to introduce the topic in future sessions. Counselors can model discussions about sex so that clients are more willing

and more comfortable with initiating discussions about sex outside of therapy (Estrada & Holmes, 1999). A counselor's lack of sexual comfort can be harmful to the counseling relationship (Masters & Johnson 1970; Weerakoon & Stiernborg, 1996). Without exploring their own sexuality, counselors are unable to create all of the necessary and sufficient conditions for therapy, which is a requisite for Rogers's person-centered therapy.

According to Prockaska and Norcross (2007), Rogers has explained that there are six necessary and sufficient conditions for therapy: relationship, vulnerability, genuineness, unconditional positive regard, accurate empathy, and perception of genuineness. If the client does not trust the counselor, it is unlikely that the therapy will be successful. The client is seeking help from the counselor and is therefore vulnerable and in a state of anxiety. It is important that the counselor be genuine in the counseling relationship. Counselors must fully be themselves in sessions. In fact, counselors may even use self-disclosure if they are being genuine (Prochaska & Norcross, 2007). In the context of discussing sexuality, counselors might even discuss how the topic of sex is anxiety-provoking to them and how they have worked to reach higher levels of sexual comfort. Counselors should offer clients unconditional positive regard and treat clients with total acceptance and without judgment (Prochaska & Norcross, 2007; Rogers, 1942; Rogers, 1951). Thus, clients should feel safe to initiate any topic, including sexual urges, with their counselor without fear of judgment. (Rogers, 1942).

If counselors are uncomfortable discussing sexual issues and clients initiate discussion about their sexuality, counselors are unlikely to be able to offer clients unconditional positive regard. If clients sense the counselor's discomfort with the topic, they may choose not to introduce the topic again. This could unfortunately mean that clients will never grow in understanding their sexuality and it may very likely limit the process of self-actualization.

Accurate empathy needs to be communicated to the client, according to Rogers. Counselors need to convey to their clients that they have an understanding of the clients' world and feelings. If clients do not feel that their counselors empathize with them, then clients are unlikely to believe that their counselors accept them with positive regard (Prochaska & Norcross, 2007; Rogers, 1942).

Rogers' final necessary and sufficient condition of therapy is perception of genuineness. It is important for the client to believe that the counselor is truly accepting and understanding. If clients believe that their counselor is behaving in an artificial way, they may not learn to trust their counselor (Prochaska & Norcross, 2007; Rogers, 1942). Counselors may be genuine in the way they discuss every other topic that clients introduce in therapy, but if counselors avoid the topic of sexuality, they are not being truly accepting of the client. If counselors perceive their clients as sexually deviant in some way due to differing beliefs regarding sex, then counselors are unable to offer clients unconditional positive regard. Counselors' behavior and view of their roles and attitudes all influence the therapeutic relationship, so it is important for counselors to explore their own attitudes and behaviors and work towards self-actualization so that they can accept and understand the attitudes of their clients (Giami & Pacey, 2006; Hilton, 1997; Rogers, 1951; Weerakoon & Stiernborg, 1996).

It is only natural for counselors to consider themselves to be self-actualizing, as counselors have received extensive training during which they learn theories and techniques for helping others. Throughout the training process, there are many opportunities for counselors to learn about themselves, as well. Counselors want to feel they have reached a place of self-awareness, though in fact, not every counselor is self-actualizing. Rogers believed that incongruence between what individuals believe to be true about themselves and what is actually

true is at the core of psychological maladjustment. Individuals often see themselves as the person they would like to be (Prochaska & Norcross, 2007). Counselors may also see themselves as the counselor they would like to be. When incongruence occurs between who individuals want to be and who they actually are, individuals often put defenses in place. These defenses exist so that individuals can maintain their concepts of self and avoid seeing their real selves. If individuals see something in themselves that is inconsistent with their self-perception, they are likely to view it as threatening. Individuals may use rationalization, denial, projection, or distortions to avoid a realization that threatens their self-concept (Prochaska & Norcross, 2007; Rogers, 1951). If individuals do become aware of these inconsistencies, they will move into a state of anxiety. Rogers believes all humans have inconsistencies in their lives that challenge their concepts of self. Everyone will use defenses to preserve these self-concepts. However, defenses take their toll on the individual (Prochaska & Norcross 2007; Rogers 1951). All humans have some sort of incongruence in their lives, and so must counselors. It is important to explore how this incongruence might influence their clients.

Counselors are human, and it is very much a part of human nature to see oneself in the best light. Therefore, some counselors may not recognize that they are not self-actualizing. These counselors may have difficulty recognizing their own discomfort addressing sexual issues. Sexuality is also a part of human nature, and if counselors are not comfortable discussing sexual issues with their clients, they are not self-actualizing. I believe that many counselors are uncomfortable discussing sexual issues with their clients. Very few counselor education programs educate or train their students in human sexuality or how to discuss sexual issues with clients (Ford & Hendrick, 2003; Gray, Cummins, Johnson, & Mason, 1989; Hilton, 1997). Sex is often considered to be a taboo topic, in part because individuals have such differing opinions

on a variety of issues surrounding sex. It follows that counselors might not feel comfortable discussing sex, and yet, it is an important aspect in any individual's life and should not be ignored, in therapy or in a counselor's own development. Counselors should explore their personal comfort levels with sex and the discussion of sex with clients as they work towards self-actualizing. Through their own exploration of sexuality, self-discovery and the process of self-actualizing, counselors may learn ways to assist their clients in their sexuality exploration. Counselors then also have the means to create safe environments in which their clients may explore their sexuality. In this way, counselors are better able to meet the necessary and sufficient conditions of therapy, which Rogers found so critical to the process and outcome in a therapeutic situation.

Purpose of the Study

The purpose of this study was to examine the factors that influence counselors' sexual comfort and willingness to discuss sexuality and sexual issues with couples they are counseling. I explored the relationship between the two dependent variables: counselors' sexual comfort, as defined by Graham and Smith (1984), and counselors' willingness to discuss sexual issues with couples they counsel. The independent variables were counselors': sexual attitudes, training and experience in discussing sexual issues, sexual knowledge, supervision experience addressing sexuality, and clinical experience discussing sexual issues. I sought to determine if these variables had a relationship with counselors' sexual comfort and counselors' willingness to discuss sexual issues with couples they counsel. My expectation was that counselor educators would be able to utilize the findings to increase counselors' in training sexual comfort and willingness to discuss sexual issues with the couples they counsel.

General Research Question

To what extent are counselors discussing sexual issues with couples they are counseling?
What factors influence the extent to which the counselors are comfortable or willing to discuss sexuality with couples they counsel?

Research Questions

- Research Question 1: Is there a relationship between counselors' sexual comfort and the extent to which they discuss sex with couples whom they are counseling?
- Research Question 2: Is there a relationship between counselors' sexual comfort and their sexual attitudes, training experience in sexual issues, sexual knowledge, supervision experience addressing sexuality, and clinical experience with sexual issues?
- Research Question 3: Is there a relationship between the extent to which counselors discuss sexual issues with couples they counsel and the following factors: counselors' sexual attitudes, training experience in sexual issues, sexual knowledge, supervision experience addressing sexuality, and clinical experience with sexual issues?
- Research Question 4: Which influencing variables (sexual attitudes, training experience in sexual issues, sexual knowledge, supervision experience addressing sexuality, and clinical experience with sexual issues) predict a counselor's comfort level with sexuality?
- Research Question 5: Which influencing variables (sexual attitudes, training experience in sexual issues, sexual knowledge, supervision experience

addressing sexuality, and clinical experience with sexual issues) predict the extent to which counselors discuss sexual issues with couples they counsel?

Research Question 6: Is there a relationship between the sexual comfort of counselors and counselors' sex, age, strength of faith, sexual orientation, number of years practicing, practice setting, type of license, type of graduate specialization, or relationship status?

Research Question 7: Is there a relationship between the extent to which counselors discuss sexual issues with couples they counsel and counselors' sex, age, strength of faith, sexual orientation, number of years practicing, practice setting, type of license, type of graduate specialization, or relationship status?

Importance of the Study

In my study, I measured counselors' willingness to discuss sexual issues with couples, sexual comfort, sexual attitudes, sexual knowledge, training experience with sexual issues, supervision experience addressing sexuality, and clinical experience with sexual issues. I chose to focus on counselors' work with couples because of the importance sex has in relationships (Byers, 2005; Donnelly, Guo & Huang, 2005; Hatfield et al., 1982; McCabe, 1999; 1993; Sprecher, 1998; 2002). I believe sexual issues should be explored and confronted with both partners present. Harris and Hays (2008) were two of the first researchers to empirically study therapists' willingness to discuss sexual issues with clients. My study extended Harris and Hays's research by focusing specifically on whether or not counselors explore sexuality in couples counseling.

Harris and Hays (2008) examined marriage and family therapists' (MFT): willingness to discuss sexual issues with clients, sexual comfort, sexual knowledge, sexuality education and training, clinical experience with sexual issues, and supervision experience in addressing sexuality. I used Harris and Hays's research as a practical and theoretical precursor to my study. My study differed from Harris and Hays's in several ways. Harris and Hays surveyed only MFTs. I surveyed counselors who were members of the American Counseling Association (ACA). My hope was to discover whether or not the findings would be consistent in other fields of counseling and for counselors in general by surveying licensed professional counselors (LPC) and licensed marriage and family therapists (LMFT). I utilized some of the scales and measurement tools developed by Harris and Hays. However, I used different measurement tools to measure counselors' sexual comfort, sexual attitudes, and sexual knowledge. Unlike Harris and Hays, I examined counselors' sexual attitudes as one of the variables. In addition, I compared the findings with counselors' willingness to discuss sexual issues with couples specifically, heterosexual and homosexual, rather than all clients in general. Other researchers have tested some of the variables that I explored, such as counselors' sexual comfort, sexual attitudes, and sexual knowledge (e.g., Anderson, 2002; Arnold, 1980; Ford & Hendrick, 2003; Haboubi & Lincoln, 2003; McConnell, 1976; Meisel, 1977). The results of these studies are often conflicting, which is why I included counselors' sexual comfort, sexual attitudes, and sexual knowledge as variables in my study. Arnold's study found no relationship between counseling students' comfort level working with clients' with sexual issues and their sexual knowledge, level of education, and personal sexual experience. These results conflict with Harris and Hays's (2008) finding that as counselors' sexual knowledge increases, so does their level of sexual comfort. Anderson did not find a relationship between sexual knowledge and

sexual comfort, although she maintains that knowledge about sex is an important factor in increasing counselors' willingness to discuss sexual issues with clients (Anderson, 2002). Therefore, it is important to examine the education and training opportunities regarding sex and sexuality that are available in counselor education programs.

Assumptions

The following assumptions were made in this research study:

1. Counselors are more likely to discuss sexual issues with their clients if they are comfortable with sex in general.
2. Counselors who responded to the questionnaire gave accurate and honest answers.
3. The LPCs and LMFTs who responded to the questionnaire are a representative sample of the larger population of LPCs and LMFTs in the USA.
4. The instruments that were used in this study are reliable and valid and accurately measure sexual comfort, counselors' discussion of sexual issues with couples, sexual attitudes, sexual knowledge, training experience in sexual issues, supervision experience addressing sexuality, and clinical experience with sexual issues.

CHAPTER TWO

Literature Review

Introduction

To prepare to conduct my study, I reviewed bodies of literature on the following topics: health professionals' and counselors' willingness to discuss sexual issues with clients; sexual comfort, sexual attitudes, and knowledge, training and education experience in human sexuality; clinical experience with clients' sexual issues; supervision experience regarding with sexuality; and sex and couples' counseling modalities.

According to numerous research studies, health professionals' and counselors' sexual comfort, sexual attitudes, and sexual knowledge may influence how healthcare professionals and counselors work with clients regarding their sexual concerns (Anderson, 2002; Ducharme & Gill, 1990; Haboubi & Lincoln, 2003; Harris & Hays, 2008; Masters & Johnson, 1970; Stayton, 1998; Weerakoon & Stiernborg, 1996). Counselors' education and training experience regarding sexual issues are important to address because these factors may influence counselors' ability to work with clients or couples with sexual concerns or issues (Bonner & Gendel, 1989; Mann & Wallace, 1975; Stayton; Weerakoon & Stiernborg, 1996). It is essential to specifically explore these issues regarding couples' counseling in order to better understand the importance of addressing sexuality and sexual issues in therapy (Andrews, 2000; Guldner & Guldner, 1992; Masters & Johnson 1970; Meisel, 1977).

Little empirical research has been conducted on counselors' willingness to discuss sexual issues with clients, sexual comfort, sexual attitudes, and sexual knowledge. There is a larger body of literature on these variables as they relate to healthcare professionals in general. Generally, physicians, nurses, rehabilitation counselors, and other healthcare professionals

recognize sexuality as an important aspect in the overall health of an individual, so there is literature that focuses on the importance of addressing clients' sexuality in providing holistic healthcare (Weerakoon & Stiernborg, 1996). As a result, there is a larger body of literature focusing on training for these types of healthcare professionals in addressing clients' sexual concerns, increasing their sexual knowledge, and the importance of exploring their own sexual attitudes and beliefs regarding sex (Stayton, 1998; Weerakoon & Stiernborg, 1996). There is some literature on counselors in training regarding these issues, but very little on practicing counselors. Specifically, some research has been conducted on counselors in training and their sexual knowledge, sexual comfort levels, and overall training in dealing with clients' sexual concerns (Anderson, 1986; Humphrey, 2000; McConnell, 1976). Very little research focuses on practicing counselors and their ability to address clients' sexual concerns (Harris & Hays, 2008). Most of the literature regarding practicing counselors is theoretical in nature. Only a few researchers (Anderson, 2002; Harris & Hays, 2008) have empirically tested some of the constructs I measured in my study.

Due to the limited literature available on these subjects, I reviewed the literature as it relates to counselors overall and other healthcare professionals. The literature on healthcare professionals highlights many of the same issues counselors have regarding sexual comfort levels, sexual knowledge, sexual attitudes, training, and experience addressing sexual issues with clients. Therefore, both bodies of literature help to illuminate the variables used in my study.

In reviewing the literature, I found an especially large body of literature written on these subjects in the 1960s and 1970s, most likely related to the increased attention to sexuality after the sexual revolution. The sexual revolution was a social movement towards more liberal expression of sexual behavior. It was a movement away from the traditional view of sex as

something reserved for heterosexual, monogamous, and married couples. The birth control pill played a significant role in the development of the sexual revolution, which allowed women the freedom to engage in sexual behaviors with less fear of unwanted pregnancies. Since the 1970s, new research on counselors and healthcare professionals and issues regarding sexuality has steadily decreased, yet I do not believe the issue of sexuality and sexual issues among clients has become any less important, which is why I believe it is important to address this topic as it relates to counselors.

Health Professionals' Willingness to Discuss Sexual Issues with their Clients

I chose to review the literature on healthcare professionals' willingness to discuss sexual issues with clients because if other more established professionals such as doctors, nurses, and psychiatrists have problems discussing sexuality with clients, counselors may also be inclined to have difficulties. In addition, the roles of healthcare professionals in the delivery of healthcare are very much intertwined. The healthcare professionals referred to here are a mixture of doctors, nurses, rehabilitation counselors, psychiatrists, psychologists, social workers, and counselors. These healthcare professionals generally believe that when sexuality is not addressed, it may be detrimental to the health of the client (Weerakoon & Stiernborg, 1996). Therefore, most healthcare professionals feel that addressing a client's sexuality is necessary in the practice of holistic care (Weerakoon & Stiernborg, 1996). Due to its importance in client care, Haboubi and Lincoln (2003) studied various health professionals' (nurses, doctors, and therapists) views on discussing sexual issues with their clients. They used survey design and received 813 surveys completed by healthcare professionals. They found that most healthcare professionals in the study (90%) believed that addressing sexual issues is important in order to provide quality care to clients. However, 68% of the healthcare professionals never initiated

discussions about sexual issues with their patients (Haboubi & Lincoln, 2003). In a follow up study, Hautamaki, Miettinen, Kellokumpu-Lehtinen, Aalto, and Lehto (2007) conducted research on healthcare professionals' experience discussing sexual issues with cancer patients. They sent out a questionnaire to healthcare professionals at Tampere University Hospital, a University hospital in Finland. They received 215 completed surveys from doctors, nurses, and other healthcare professionals employed in the cancer ward. Healthcare professionals in the internal medicine, neurology, urology, and gynecology wards were also surveyed. The majority of healthcare professionals reported that they discussed sexual issues with less than 10% of their clients. Most healthcare professionals said they rarely gave their clients the chance to address their concerns about sex.

In cases involving rehabilitation therapy, Ducharme and Gill (1990) expressed the need for professionals to address sexuality with their clients suffering from traumatic head injuries. Many of these clients display decreased sexual functioning, control, and/or desire. These difficulties can lead to poor body image, decreased self-esteem, and issues with sexual identity, and it is important for rehabilitation professionals to give their clients permission to discuss these or any other sexual concerns. There appears to be a disconnect between healthcare professionals' belief that discussing sexual issues with clients is important and putting this belief into practice.

Haboubi and Lincoln (2003) found that inadequate training, lack of time, and embarrassment were the main reasons why healthcare professionals felt they did not address sexual issues with their clients. Client age, health, gender, and relationship status were also factors (Haboubi & Lincoln, 2003). Based on their study, they believe younger healthcare professionals may be less likely to discuss sexual issues with older adults. They found that the

gender of healthcare professionals may be an influencing factor in their ability to communicate effectively about sex as well. Haboubi and Lincoln found male healthcare professionals to be more comfortable than females in discussing sexual issues with their clients. Male healthcare professionals tended to initiate the discussion of sexual issues more often than females. Lack of training and embarrassment were reasons for female healthcare professionals' lack of willingness to discuss sexual issues with clients. Female healthcare professionals felt more training would increase their comfort levels in discussing sexuality. In Hautamaki et al.'s study (2007), healthcare professionals were asked why they did not discuss sexual issues with their clients, and the following responses were given: lack of time, lack of education, lack of training, and difficulty discussing the topic. Nurses felt that lack of education and difficulty discussing the topic of sex were the main reasons they did not discuss sexual issues with clients. Doctors were more likely to report lack of time as the reason for not discussing sexual issues (Hautamaki et al., 2007). So, although healthcare professionals believe that discussing clients' sexual issues is important, they resisted initiating these discussions due to lack of training, lack of time, and embarrassment (Haboubi & Lincoln, 2003).

As has been discussed, there is consensus among healthcare professionals that it is important for healthcare professionals to initiate the discussion of client sexual issues (Ducharme & Gill, 1990; Haboubi & Lincoln, 2003; Hautamaki et al., 2007; Weerakoon & Stiernborg, 1996). Clients then have the option to share their feelings, end the discussion, or continue discussing at another time (Hautamaki et al., 2007). Ducharme and Gill have suggested many ways to improve healthcare professionals' willingness to discuss sexual issues with clients. Ducharme and Gill believe rehabilitation professionals need to be nonjudgmental, sensitive, and supportive listeners. They also need to be comfortable with their own sexuality to ensure that

they do not communicate their own anxiety, shame, or attitudes, verbally or non-verbally, to their clients. Their communication regarding sex and sexuality needs to be clear and free of judgment. The ability to effectively communicate with clients about sex and sexuality calls for both solid knowledge about sex and sex issues as well as effective general communication skills (Ducharme & Gill, 1990).

Improving healthcare professional students' ability to effectively communicate about sexual issues and sexuality can be accomplished by providing students with up-to-date information about sex and encouraging them to express themselves through presentations, journals, research papers, and process groups (Graham & Smith, 1984). Graham and Smith emphasized how important it is that healthcare professionals increase their knowledge about sex and explore their attitudes about sex in order to improve their ability to communicate about sex. Increasing their sexual comfort levels may improve healthcare professionals' ability to effectively and openly communicate about sex, as well. According to Graham and Smith, students' willingness to communicate about sexuality should increase as they become more comfortable with their own sexuality.

According to Bonner and Gendel (1989) healthcare professionals' sexual attitudes, much like their sexual comfort, may impact their abilities to discuss sexual issues with clients. Healthcare professionals must take into consideration that a person's sexuality is influenced by many factors, including: religious and/or spiritual beliefs, ethnicity, culture, socioeconomic status, level of education, and family background. It is important for healthcare professionals to explore their own sexuality and consider how it may differ from their clients, based on these factors (Bonner & Gendel, 1989).

Clearly, research has found that healthcare professionals have difficulties discussing sexual issues with clients (Haboubi & Lincoln, 2003). However, one might expect counselors to be better equipped and more likely to discuss sexual issues with clients. Often, medical healthcare professionals will refer their clients with sexual concerns to counselors. However, Haboubi and Lincoln found in their survey that therapists were less likely than doctors and nurses to be trained in sexuality issues or to initiate discussion of sexual issues with clients.

Counselors' Willingness to Discuss Sexual Issues with their Clients

According to Hilton (1997), clients often indicate that sexual issues are a motivating factor for seeking and beginning therapy. If therapy is long term, it is very likely that sex and sexuality will need to be explored (Hilton, 1997). Guldner and Guldner (1992) have found that counselors tend to avoid the topic of sex and sexuality when providing couples' counseling. Many counselors reported that they wait for their clients to initiate the discussion of sex and sexuality. This seems to contradict counselors' behavior regarding the initiation in discussion of other topics, as counselors generally do not wait for clients to initiate other topics. So why do counselors avoid the topic of sexuality? Counselors who have not been formally trained in dealing with clients' sexual issues and have discomfort with sex and sexuality in general tend to avoid the topic (Guldner & Guldner, 1992). Other researchers have found that avoidance of and discomfort with sexual issues is present during counselor training, as well. Anderson (1986) found that, in general, counselors in training are uncomfortable discussing sexual issues. Avoiding clients' sexual issues can result in negative outcomes. Clients may continue to experience issues with unresolved trauma and sexual dysfunction. Furthermore, continued sexual issues may lead to increased relationship problems (Gray et al., 1989).

Sex is an unavoidable part of human nature and therefore should be an unavoidable part of the therapeutic relationship. Even if counselors are uncomfortable with the topic, it is their responsibility to process sexual issues with clients as they arise. Many clients have some form of sexual issue, ranging from body image to abuse or trauma, and it is important for clients to work on these issues (Hilton, 1998). It is detrimental to the client if the counselor is not willing to explore these issues due to the counselor's own anxiety, discomfort, or lack of training on the topic (Hilton, 1998). Negative outcomes associated with ignoring sexual issues include divorce, anxiety, and depression (Gray et al., 1989). In order to avoid the incidence or continuation of these issues in clients, it is important to gain an understanding of the factors that influence counselors' willingness to discuss sexual issues with clients.

Arnold (1980) conducted a study to examine the relationship between counselors' in training sexual knowledge and attitudes and their willingness and comfort working with clients' sexual issues. If counselors avoid clients' sexual concerns, they run the risk of enforcing negative messages and beliefs that clients may have received regarding sex, such as the belief that sex is wrong, dirty, and sinful (Arnold, 1980). Arnold used a treatment group and a control group to study the impact of counselors' anxiety on these issues by having counselors complete personal sexuality questionnaires that explored their comfort levels in and willingness to address client sexual issues. The treatment group completed an examination of their personal sexuality prior to measuring their comfort and willingness working with clients with sexual concerns. The control group completed the examination of personal sexuality after their comfort levels and willingness in dealing with clients' sexual issues were measured. No difference was found between the treatment and control group in terms of counseling student's willingness to address clients' sexual concerns. Therefore, any discomfort and anxiety created from completing the

personal sexuality questionnaire did not influence counseling students' willingness to deal with client's sexual issues.

Another researcher examined counselors' willingness to discuss sexual issues with adolescent clients. Roche (1998) wanted to discover if relationships existed between high school counselors' sexual comfort, HIV knowledge, sexuality education, and willingness to discuss sexual issues with adolescent clients. Roche conducted a correlation and multiple regression analysis on the following variables: high school counselors' sexual comfort, HIV knowledge, sexuality education, and willingness to discuss sexual issues with adolescent clients. Roche mailed surveys to high school counselors working in public schools in Connecticut and received 273 completed surveys. The surveys consisted of demographic items, an adaptation of the *Willingness to Address Client Sexual Concerns (WACSC)*, an assessment of educational experiences in human sexuality created by Roche, the *Sexual Comfort Instrument (SCI)*, and the *HIV-Knowledge Questionnaire*. Roche found a positive relationship between high school counselors' sexual comfort and their willingness to discuss sexual issues with adolescent clients. As high school counselors' sexual comfort increased, so did their willingness to discuss sexual issues with adolescents. Roche found that high school counselors' willingness to discuss sexual issues with adolescent clients had a stronger relationship when the variables (high school counselors' sexual comfort, human sexuality education, and HIV knowledge) were present simultaneously rather than any one of these variables alone. High school counselors' sexual comfort had a stronger relationship with high school counselors' willingness to discuss sexual issues with adolescent clients than any other single variable (Roche, 1998).

Roche's research was a precursor to Anderson's (2002) study of counselors' sexual comfort. Anderson discovered that there may be a combination of factors that influence

counselors' sexual comfort or willingness to discuss sexuality with clients, including counselors': sexual attitudes, training experience with sexual issues, and personal sexual experience (Anderson, 2002). Counselors are often concerned about when it is appropriate to discuss sexuality. If counselors are knowledgeable about sexuality and comfortable discussing sexuality, they are generally not as concerned about when discussion is or is not appropriate. Instead, these counselors examine how important the sexual issue is in relation to the client's other concerns, according to Meisel (1977).

In a more recent study, Harris and Hays (2008) examined factors that influence marriage and family therapists' (MFT) willingness to initiate sexual discussions with their clients. The variables measured were therapists' sexuality education, supervision experience addressing sexual issues, clinical experience addressing sexual issues, perceived sexual knowledge, and sexual comfort. Based on available literature, Harris and Hays hypothesized that each of these variables was related to a marriage and family therapist's willingness to initiate sexual discussions with clients. Although previous researchers had assumed that these variables were related to a therapist's willingness to initiate sexual discussions with clients, Harris and Hays were the first to empirically test these assumptions. In addition to the above variables, Harris and Hays measured several demographic variables. They found that the strongest predictors for whether or not marriage and family therapists would initiate sexual discussions with their clients were sexuality education and supervision experience with sexual issues. MFTs' perceived sexual knowledge and sexual comfort levels increase when they receive more sexuality education and supervision experience with sexual issues. The second greatest predictor in determining whether or not MFTs would initiate sexual discussion with clients was their sexual comfort levels. Higher levels of perceived sexual knowledge were shown to increase MFTs'

sexual comfort levels. In other words, when MFTs believe they have high levels of sexual knowledge, they become more comfortable with sexuality and are therefore more willing to initiate sexual discussions with clients.

Harris and Hays (2008) believe sexuality education and supervision experience with sexual issues are the foundation of MFTs' sexual comfort. MFTs gain knowledge through their sexuality education and supervision and as a result increase their sexual comfort levels. Further, Harris and Hays believe that if MFTs do not receive sexuality education and supervision experience with sexual issues, it is unlikely their sexual comfort levels will increase. MFTs' perceived sexual knowledge was found to be a greater influence on the extent to which they will initiate sexual discussions with clients than actual sexual knowledge. Increased perceived sexual knowledge influences MFTs' sexual comfort and as a result, they are more likely to initiate sexual discussions with clients. MFTs' willingness to initiate sexual discussions with clients was not directly influenced by perceived sexual knowledge or actual sexual knowledge. MFTs' age, gender, level of education, discipline, years of practice, and number of clients seen weekly did not influence their willingness to initiate sexual discussions with clients. This further emphasizes the importance of sexuality education and supervision experience working with clients' sexual issues. Regardless of age, gender, level of education, discipline, years of practice, and the number of clients seen, sexuality education and weekly supervision experience addressing sexual issues increase MFTs' willingness to initiate sexual discussions with clients (Harris & Hays, 2008). Further, Harris and Hays found that certified sex therapists were more likely to initiate sexual discussions with clients than non-certified sex therapists. Certified sex therapists have higher levels of sexuality education and supervision experience addressing sexual issues, further supporting the findings.

I used Harris and Hays's study as the precursor to my study. Harris and Hays were the first to empirically test therapists' willingness to discuss sexual issues with their clients. In my study, I measured many of the same variables measured by Harris and Hays. Other researchers have measured some of the variables, including counselors' sexual comfort levels, sexual attitudes, and sexual knowledge (e.g., Anderson, 2002; Arnold, 1980; Ford and Hendrick, 2003; Haboubi and Lincoln, 2003; McConnell, 1976; Meisel, 1977). The results of these studies are often conflicting, which is why the variables used were included in my study. I used some of the scales Harris and Hays developed for their study. However, I used different scales to measure counselors' sexual comfort levels, sexual attitudes, and sexual knowledge. Unlike Harris and Hays, I examined counselors' sexual attitudes as one of the variables. In addition, I compared the findings with therapists' willingness to discuss sexual issues with couples specifically, both heterosexual and homosexual, rather than all clients in general. Although exploring sexuality is important for all individuals, I believe it is a major component in couples' counseling. The sexual relationship is an important aspect of any romantic relationship and therefore should not be overlooked in therapy. In addition, many couples and individuals expect their counselors to be able to address their sexual concerns.

There is a general assumption that counselors are equipped to deal with clients' sexual issues (Gray et al., 1989). Clients expect their counselors to be both knowledgeable and comfortable with sexuality. Sexuality is a part of any individual, and it can influence his or her self-esteem, intimacy, family, relationships, and self-acceptance. Sexuality is a sensitive issue for clients and can leave clients feeling vulnerable, so it needs to be approached with sensitivity and acceptance (Gray et al., 1989). Supporting this, Kirkpatrick (1980) believes that in order for counselors to be able to discuss clients' sexual issues with as much ease as other issues,

counselors must possess open-mindedness and non-judgmental attitudes concerning sexuality. Similarly, Hilton (1997) asserts it is important for counselors to be comfortable with their own sexuality and sexual attitudes, have an understanding of their own sexual issues, and have an understanding of how their own issues might influence their abilities to provide clients with what they need.

Counselors' and Healthcare Professionals' Sexual Comfort, Attitudes, and Knowledge

Sexual Comfort.

Graham and Smith (1984) conducted a study to develop a definition of sexual comfort. They surveyed sex educators, and the following definition was developed based on the results. "Sexual comfort is a broad, complex construct involving cognitive, affective, and behavioral responses to sexuality; as well as a developmental task influenced by the physiological, psychological, sociological, spiritual or religious, educational, and sexual aspects of one's being" (Graham & Smith, 1984, p.439). Graham and Smith found that sex educators believe sexual feelings and attitudes, acceptance of others, and communication skills are all important aspects of sexual comfort. I used this definition of sexual comfort in my study.

Researchers have hypothesized that sexual attitudes, knowledge, and values influence sexual comfort (Weerakoon & Stiernborg, 1996). Sexual discomfort is seen as a deterring factor in whether or not healthcare professionals provide quality sexual healthcare for their clients. When healthcare professionals are uncomfortable with sexuality and sexual issues, they may as a result avoid addressing clients' sexual issues (Weerakoon & Stiernborg, 1996). Some suggest that healthcare professionals' willingness to discuss sexual issues with their client is influenced more by healthcare professionals' perception of the client's sexual comfort, attitudes, and values, than by their own. If healthcare professionals perceive the client's sexual values and attitudes as

being different from their own, they may be less likely to initiate a sexual discussion (Weerakoon & Stiernborg, 1996).

Some researchers believe or have found that counselors do not discuss sexuality with clients due to counselors' own anxiety or discomfort with sexuality. For example, Ducharme and Gill (1990) believe that many rehabilitation professionals do not address sexuality with their clients due to their own anxiety. Anderson (1986) collected four years worth of feedback from counseling students regarding their experiences in a human sexuality course. In Anderson's study, counselors in training reported feeling embarrassed, anxious, shocked, angry, and sexually aroused along with a variety of other negative feelings when exposed to clients with sexual concerns (Anderson, 1986) Anderson researched students who would be less likely to have the experience that practicing counselors do.

Also, researchers believe sexual anxiety or discomfort can result in healthcare professionals avoiding inquiry into a client's sexual history (Weerakoon & Stiernborg, 1996). Weerakoon, Jones, Pynor, and Kilburn-Watt (2004) conducted research examining healthcare professional students' perceived comfort levels in a variety of clinical interactions involving sexuality. Many students believed they would feel uncomfortable in a variety of these interactions. The students reported that they would feel uncomfortable requesting sexual information from their clients. The majority of students reported that they would feel uncomfortable with a client who made either overt or covert sexual remarks. More male students than female students reported that they would feel uncomfortable working with a homosexual male client. More female students than male students reported that they would be uncomfortable working with a lesbian client (Weerakoon et al., 2004). In a follow-up study, Jones, Weerakoon, and Prynor (2005) surveyed occupational therapy students' level of comfort dealing with clients'

sexual issues or behaviors. They found that over half of the students expected to be uncomfortable working with clients with sexual issues. The students expected high levels of discomfort with the majority of the items on the questionnaire. The items with which the students predicted they would be most uncomfortable dealing were items that described clients making overt or covert sexual remarks and walking in on a client masturbating. However, male students reported that they would be more comfortable dealing with these issues than female students.

Arnold (1980) conducted a study on sexual comfort that focused on counseling students. He found that counseling students who did not complete an examination exploring their personal sexuality prior to measuring their comfort and willingness in working with clients' sexual issues had higher levels of comfort working with clients' sexual concerns than students who did complete a personal sexuality examination. Arnold believed these results were due to the fact that the examination of the students' personal sexuality evoked anxiety and, as a result, the students were less comfortable working with others' sexual concerns. These results regarding counseling students' discomfort in working with clients' sexual issues are consistent with the results of Weerakoon et al. (2004) and Jones et al. (2005) on healthcare professionals' sexual comfort levels. Arnold's study found no relationship between counseling students' comfort level working with clients' sexual issues and sexual knowledge, level of education, and personal sexual experience. These results conflict with Harris and Hays's (2008) finding that as counselors' sexual knowledge increases, so do their sexual comfort levels. I measured counselors' sexual comfort in my study to examine this discrepancy.

Fluharty (1995) conducted a study on therapists' comfort levels when clients present with sexual concerns. She measured the following variables in her study: therapists' comfort with

clients' sexual issues, sexual knowledge, training experience, gender, and the gender of the client. Seventy-five psychologists and psychologists in training participated in her study. Fluharty used client actors and videotaped them presenting with the problem of inhibited sexual desire. In the video, the actors paused to allow the psychologists to respond. The participants were then audiotaped as they responded to the client actors in the videotape. The audiotapes were analyzed to see if the psychologists or psychologists in training made any avoidant responses. Fluharty measured the therapists' comfort by their avoidant responses, measuring their state anxiety, and testing their cognitive interference before and after the session. In addition, Fluharty measured their sexual knowledge using the *Sex Knowledge and Attitude Test* (SKAT). Fluharty found male therapists to be more uncomfortable, when clients presented with sexual concerns, than female therapists. Neither therapists' levels of training nor client sex affected this finding. Male therapists used more avoidant responses. Fluharty did not find a relationship between therapists' sexual comfort and sexual knowledge. No relationship was found between the therapists' sex and the clients' sex (Fluharty, 1995).

Roche's (1998) findings in her study regarding counselors' sexual comfort and sexual knowledge differed from Fluharty's findings. Roche found a positive relationship between high school counselors' sexual comfort and their levels of human sexuality education. Of the high school counselors' surveyed, those with higher levels of human sexuality education had higher levels of sexual comfort than those with less human sexuality education (Roche, 1998).

When looking at healthcare professionals, Haboubi and Lincoln (2003) found therapists to be more uncomfortable discussing sexual issues than doctors and nurses. If therapists are uncomfortable discussing sexual issues with their clients, they run the risk of alienating their clients if they are not accepting of their clients' sexual beliefs and practices, comfortable with

sexuality, and confident in their knowledge of sexuality and their abilities to assist clients (Masters & Johnson, 1970).

Due to the need for counselors to be comfortable addressing sexuality, Anderson (2002) conducted a study examining the relationship between various variables and counselors' sexual comfort. Anderson posited that, if counselor educators knew which variables influence counselors' sexual comfort levels, they would be better able to address these issues with counselors in training. She found that counselors with higher levels of sexual comfort were more sexually experienced. Counselors who had more liberal sexual attitudes and values had higher levels of sexual comfort. The number of years counselors practiced positively correlated with their sexual comfort. In other words, counselors who had been practicing longer had higher levels of sexual comfort. The more sexuality training counselors have received, the more comfortable they were with sexuality and sexual issues. Of all the variables measured, a counselor's sexual attitude was the greatest predictor of high levels of sexual comfort. The combination of variables that best predicted increased levels of sexual comfort in counselors were sexual attitudes, training experience in sexuality and sexual issues, and personal sexual experience. Although it is an interesting finding that counselors with more personal sexual experience have higher levels of sexual comfort, Anderson did not suggest that counselor educators focus on this variable. Counselor educators should work to increase their students' levels of sexual training and try to promote more liberal sexual attitudes. Anderson stipulated in her study that counselors cannot and should not encourage their students to increase their personal sexual experience (Anderson, 2002).

According to Stayton (1998), sexual trauma, sexual ignorance, sexual secretiveness, and the new phenomena in the history of human sexuality are the main factors that contribute to the

anxiety and sexual discomfort that healthcare professionals and individuals in general experience in addressing sexuality. Sexual trauma may result from a repression of sexual feelings. Our society has developed standards of sexual functioning (Stayton, 1998). It is considered “normal” and “acceptable” sexual behavior for married, monogamous, heterosexual couples to engage in sex, and specifically, the missionary position. According to Stayton, individuals are born sexual beings with many different sexual desires. However, they learn what is deemed appropriate by society. Masturbation, homosexuality, and promiscuity are a few sexual behaviors that are considered deviant in our society. Sexual ignorance is simply not having an understanding or knowledge of sex and sexuality. Places and environments considered appropriate for individuals to learn about sex are always up for debate in our society. Should parents, schools, or religious organizations teach our children about sex? The lack of agreement on this issue results in a lack of sexuality education. Sexual secretiveness occurs because individuals are taught that sex and sexuality should not be discussed openly in public. The new phenomena in the history of sexuality involve the fact that our society’s moral values and traditions are being questioned. This challenging of the traditional beliefs concerning sex and sexuality is anxiety-producing and evokes sexual discomfort in healthcare professionals (Stayton, 1998). There may be ways to decrease this anxiety and discomfort.

There is an assumption that if healthcare professionals increase their comfort level with both their own sexuality and the sexuality of others, then they will be more willing to discuss sexual issues with clients (Weerakoon & Stiernborg, 1996). It is important for human sexuality educators to assist students in the development of each of these aspects of sexual comfort (Graham & Smith, 1984).

Sexual Attitudes.

It is important for healthcare professionals to have an understanding of their own attitudes about sex and sexuality (Stayton, 1998). Many individuals have biases or judgments about a variety of sexual topics. Knowing their own biases and judgments will enable healthcare professionals to better serve their clients (Stayton, 1998). When healthcare professionals are more aware of their own attitudes about sexuality and sexual behaviors, they are less prone to judge their clients. They are more comfortable and less anxious in assisting clients with sexual concerns (Stayton, 1998). Individuals' sexuality can be influenced by their religion, culture, ethnicity, education, socioeconomic status, and family background. It is important to do no harm to clients. It is therefore important for healthcare professionals to explore their own attitudes and values and consider how this might impact their interactions with clients (Weerakoon & Stiernborg, 1996).

To reduce anxiety and train rehabilitation professionals to address sexuality with clients, Ducharme and Gill (1990) asserted that rehabilitation professionals must address their own feelings and attitudes regarding sexuality. They must be aware of their own beliefs and attitudes so they do not push their beliefs onto their clients. They need to be aware of their own biases to remain objective when working with clients. This same principle applies to counselors as well, in my opinion. According to Masters and Johnson (1970), therapists must have an understanding of their own sexuality, sexual behaviors, and sexual attitudes to assist clients with their sexual concerns

Ford and Hendrick (2003) conducted a study to address the issues that might arise if a counselor is working with a client whose sexual practices conflict with their values and personal sexual practices. They developed a questionnaire that assessed therapists' personal sexual values

and which client sexual issues they would be uncomfortable dealing with in session. The questionnaires were sent to practicing therapists. Ford and Hendrick received 318 completed surveys. They found that female counselors tended to be more comfortable working with clients with sexual orientation issues. Male counselors reported being more comfortable working with clients whose sexual practices were considered outside of societal norms, including group sex and sadomasochism. In addition, they found that even when counselors' values were different from their clients, counselors did not allow these differences to interfere with their abilities to serve their clients. Many of the counselors surveyed had good understandings of their own personal values and attitudes and took necessary steps to avoid allowing them to have a negative influence on their clients. These steps may include client referrals, facilitating open discussions with their clients, and consulting with their colleagues and supervisors. Overall, they found that counselors tended to have more liberal values about sex than their clients (Ford & Hendrick, 2003).

Research that has examined the relationship between healthcare professionals' sexual attitudes and the quality of sexual healthcare given to clients is inconclusive. Researchers have found a positive relationship between healthcare professionals' sexual attitudes and their sexual knowledge (Weerakoon & Stiernborg, 1996). Arnold (1980) found a positive relationship between counselors in trainings' sexual knowledge and sexual attitudes. The higher counseling students' sexual knowledge, the more liberal were their sexual attitudes. No relationship was found between counseling students' sexual attitudes and the amount of training they received in human sexuality (Arnold, 1980). Anderson (2002) found a significant relationship between counselors' sexual attitudes and their sexual comfort. The more comfortable counselors were with sexuality, the more liberal they were in their sexual attitudes, values, and beliefs.

There is general consensus that addressing healthcare professionals' attitudes and values about both their own sexuality and that of their clients is an objective in sexuality education. Healthcare professionals' sexual attitudes and values can influence their interaction with clients (Weerakoon & Stiernborg, 1996). Desensitization is a common technique used in educating healthcare professionals in sexuality. The goal of desensitization is to increase individuals' self-awareness regarding their sexual attitudes, values, and biases. Individual sexual values and beliefs can differ greatly. It is important for healthcare professionals to understand their biases regarding others' sexual practices. This will enable them to better serve their clients and hopefully increase their tolerance of others. Some believe that healthcare professionals must change their sexual attitudes and biases, while others believe sexuality education is important in increasing an individual's self-awareness and sexual comfort. Many sexuality educators believe increasing sexual comfort, sexual attitude, and sexual knowledge are all important in sexuality education (Weerakoon & Stiernborg, 1996).

Sexual Knowledge.

Therapists and healthcare professionals recognize the importance of sexual knowledge in being able to provide quality healthcare (Stayton, 1998). Unfortunately, it is possible for healthcare professionals to be less knowledgeable about sex and sexuality than the clients they serve. Many individuals see healthcare professionals as experts, but healthcare professionals themselves can be secretive or traumatized about sex. Increased knowledge and training in sexuality and sexual issues is important for healthcare professionals. However, based on their own attitudes, discomfort, and anxiety about sex and sexuality, healthcare professionals may not be helpful and can even perhaps be harmful to clients (Stayton, 1998).

Researchers that surveyed rehabilitation professionals in a Boston rehabilitation hospital on their attitudes and their behaviors regarding practice found that 79% of the professionals felt clients' sexual health was important; however, only 9% reported feeling comfortable discussing sexuality with clients. Many stated that they were uncomfortable discussing sexuality due to lack of knowledge or experience (Ducharme & Gill, 1990).

To examine the importance of counselors' sexual knowledge and training, McConnell (1976) conducted a study examining counselors in training and their competency in addressing clients' sexual issues. Counselors in training who had completed their theoretical training and at least one semester of clinical training were assessed on their levels of empathy, anxiety, and sexual knowledge. Each counselor was assigned a client actor who was seeking counseling regarding a sexual problem. McConnell found that the counselors were unable to display empathy towards their clients. The counselors' self-reported anxiety levels were so high, it would be unreasonable to assume they could provide effective counseling to their clients. Based on the results of the *Sex Knowledge Inventory*, the counselors' scores indicated many lacked basic sexual knowledge (McConnell, 1976). It is fair to assume that these counselors may have been more helpful to their clients if they possessed more sexual knowledge. Supporting this, Arnold (1980) found in his study that the more knowledgeable counselors in training were about sexuality, the more willing they were to work with clients with sexual concerns.

In her study, Anderson (2002) examined the relationship between counselors' sexual comfort and their sexual knowledge. Anderson did not find a significant relationship between counselors' sexual knowledge and their sexual comfort. Therefore, sexual knowledge alone does not increase counselors' levels of sexual comfort (Anderson, 2002). This conflicts with Harris and Hays's (2008) findings that when MFTs received more sexuality education and supervision

experience in addressing sexual issues, their perceived sexual knowledge and sexual comfort levels increased. Anderson's findings also conflict somewhat with Roche's (1998) findings. Roche found that the more human sexuality education high school counselors had, the more willing they were to discuss sexual issues with adolescent clients. However, sexuality education did not have a strong relationship with high school counselors' willingness to discuss sexual issues with adolescents if the high school counselor had low levels of sexual comfort.

Anderson's findings are, however, consistent with Fluharty's (1995) findings that there is no relationship between therapists' sexual comfort and sexual knowledge. According to Anderson, counselors are often concerned about when it is appropriate to discuss sexuality. If counselors are knowledgeable about sexuality and comfortable discussing sexuality, they may not be as concerned about when discussion is or is not appropriate and may be more likely to openly discuss sexual issues with clients. Even though Anderson did not find a relationship between sexual knowledge and sexual comfort, she still believes it is an important factor in increasing counselors' willingness to discuss sexual issues with clients (Anderson, 2002). Therefore, it is important to examine the sexuality education and training available in counselor education programs. In my study, I measured sexual knowledge to clarify the conflicting results and to illuminate the lack of attempt to increase students' sexual knowledge in counseling programs.

Having a general knowledge and understanding of sex and the sexual issues that clients might possess will better prepare healthcare professionals for the types of concerns they might encounter (Stayton, 1998). It is necessary for healthcare professionals to be skilled in how to handle these sexual concerns to best serve their clients (Stayton, 1998).

Improving healthcare professionals' sexual knowledge has many benefits. Increasing healthcare professionals' sexual knowledge will improve their sexual attitudes and values. As a

result, they will be more effective in addressing the sexual health of their clients (Weerakoon & Stiernborg, 1996). When healthcare professionals and counselors are knowledgeable, they become more confident in their skills. Counselors must be confident in their sexual knowledge and with sexuality in general before they can help clients (Masters & Johnson, 1970). As Harris and Hays (2008) found in their study, perceived sexual knowledge was a greater influence than actual sexual knowledge on the extent to which MFTs initiate sexual discussions with clients. Increased perceived sexual knowledge influenced MFTs' sexual comfort and, as a result, MFTs were more likely to initiate sexual discussions with clients (Harris & Hays, 2008). Increasing sexual knowledge involves more than studying human sexuality. Research suggests that individuals can more easily increase their sexual knowledge once their anxiety has decreased (Weerakoon & Stiernborg, 1996).

At the time of the study, McConnell (1976) reported that counselor training programs were not providing their students with adequate training and the knowledge they needed to assist clients with their sexual concerns. Unfortunately, over 30 years later, counseling training programs still do not seem to focus on human sexuality within their curriculums. This may be due to the fact that CACREP standards are very vague regarding incorporating sexuality into counselor education curriculums (CACREP, 2009). This also may be due to the fact that counselor educators may not feel comfortable teaching human sexuality or discussing sexuality with students.

Sexuality Education and Training

Counselors' Sexuality Education and Training.

There is a large body of literature on healthcare professionals' and counselors' education and training in human sexuality. Counselors need to have training in human sexuality to work

effectively with clients who have sexual concerns (Anderson, 1986). The skills needed to counsel clients with sexual issues are different than those necessary to work with other client concerns (Anderson, 1986). Sexuality education has been incorporated in various healthcare professional training programs for many reasons. Sexuality is an important part of every individual, and counselors have the potential to face sexual concerns with every client they see. Parents may seek out counselors to educate their children about sex and sexuality. Adolescents often struggle in their sexual identity development and may have many fears regarding sexuality. Older adults may experience lack of sexual desire or inability to perform sexually (Landis, Miller, & Wettstone, 1975).

Because sex is such a sensitive topic in our society, and because it is often associated with feelings of guilt, people have difficulty discussing sexuality (Landis et al., 1975). If counselors receive training in sexuality, they are more likely to be comfortable discussing sexuality. It is important for counselors to explore their own sexuality, sexual attitudes, and values so they do not impose their own values on their clients. Counselors who are uncomfortable with sexuality may avoid their clients' sexual issues, which could be detrimental to the client. Sexuality education training provides counselors with current information. Cultural norms and values surrounding sex and sexuality are often changing, and it is important for counselors to be aware of the cultural norms and laws surrounding sexuality. This will enable them to provide clients with proper referrals if needed. In addition, it helps counselors to be open-minded to differing values and beliefs regarding sexuality (Landis et al., 1975).

According to the Council for Accreditation of Counseling and Related Educational Programs' (CACREP) *2009 Standards*, marriage, couple, and family counseling programs should ensure that graduating students "understand human sexuality (e.g., gender, sexual

functioning, sexual orientation) and its impact on family and couple functioning “ (CACREP, 2009, p.36). CACREP views sexuality as a multicultural identity and stipulates in their standards that graduates from marriage, couple, and family counseling programs should “recognize societal trends and treatment issues related to working with multicultural and diverse family systems (e.g., families in transition, dual-career couples, blended families, same-sex couples)” (CACREP, 2009, p.37). School counseling programs need to ensure that their graduates “understand multicultural counseling issues, as well as the impact of ability levels, stereotyping, family, socioeconomic status, gender, and sexual identity, and their effects on student achievement” (CACREP, 2009, p.41). CACREP does address the need for counseling programs to educate students about sexuality; however, CACREP does not require programs to offer a human sexuality course as a required or elective course. Therefore, human sexuality learning is at the discretion of counseling programs’ interpretation of CACREP standards. Programs may not adequately cover the information counselors need to address their clients’ sexual concerns.

Kirkpatrick (1980) conducted a nationwide survey of counselor educators’ and practicing counselors’ views on what human sexuality information is important for counselors in training to learn. Every participant completed the *Sex Counseling Information Inventory* (Kirkpatrick, 1980). Both counselor educators and practicing counselors agreed that it is important for counselors in training to be aware of factual information regarding contraception, abortion, venereal diseases, puberty, and reproduction. They also believed counselors in training should be able to address various sexual concerns of clients, such as: unplanned pregnancy, virginity, first intercourse, homosexuality, gender role equality, differences in couples’ sexual behaviors, sexual dysfunction, and sexuality education. One item on the inventory that both counselor educators

and practicing counselors felt counselors in training should learn to do in their Master's programs was "discuss clients' sexuality as easily as other concerns" (Kirkpatrick, 1980, p. 279). Kirkpatrick believes human sexuality is an important aspect of life and that it should be an area in which counselors in training are educated. In society, we see increased issues pertaining to teenage pregnancy, sexual dysfunction, gender identity, sexual orientation, STDs, and a variety of other sexual issues. It is surprising that counseling programs have not incorporated human sexuality into the training of counselors, considering the prevalence of sexual issues in our society.

Lack of training.

Most counselors are forced to deal with clients' sexual issues without receiving proper training (Hilton, 1997). In many practice settings, counselors are exposed to clients with a variety of sexual issues or concerns (Fyfe, 1980). However, counselors receive very little training in human sexuality. There is not much current research on sexuality education in counseling programs. However, according to Fyfe's research in 1980, graduate schools offer very little training in human sexuality and how to help clients with sexual issues (Fyfe, 1980). According to Haboubi and Lincoln (2003), therapists are less likely than doctors and nurses to have training in sexuality.

An overall lack of course offerings and training opportunities in sexuality conveys a message that sexuality is not an important topic and that it does not need to be discussed (Gray et al., 1989). The societal message that sexuality is a taboo topic is seemingly a message that exists among healthcare professionals. Clients expect their counselors to be knowledgeable about sexuality and comfortable discussing sex. Therefore, it is important for clinical training programs to address sexuality. If counselor educators are not comfortable training their students in

sexuality, how do they expect counselors to feel comfortable addressing sexuality with their clients? A study comparing counseling, psychology, and social work students revealed that counseling students were the least knowledgeable about sexuality and sexual issues (Gray et al., 1989). Twenty years ago, Gray et al. surveyed counselor educators and found that only 16% of the programs surveyed offered a course in human sexuality. Only 20% of the human sexuality courses offered were required. Of the human sexuality courses offered, more than 40% were taught by faculty in departments other than the counseling department. Of the sexuality educators surveyed, 52% felt their programs did not emphasize enough the importance of human sexuality. I was unable to find more recent data on counselor human sexuality courses offered in counselor education programs; therefore, I chose to include the results from Gray et al.'s study. I believe the study is still relevant to the lack of emphasis on human sexuality education in counselor education programs.

In Gray et al.'s (1989) study, counselor educators reported that there had been negative responses, by both students and the community, to the human sexuality courses. Some programs reported that they were in the process of trying to introduce human sexuality courses into the curriculum. Counselor educators revealed that there is often debate in their programs as to whether or not human sexuality courses should be required. The lack of sexuality education was reportedly due to lack of staff, finances, staff training, and space in the curriculum (Gray et al., 1989). Gray et al. believed counselors will not be able to effectively address clients who have sexual concerns until counselor education programs begin to put a greater emphasis on sexuality education.

Ford and Hendrick (2003) surveyed therapists who were members of APA and/or AAMFT, and found that 22 % of the therapists surveyed had never received training in sexual

issues. Of those surveyed, 41% reported never receiving any training on how to conduct a psychosexual assessment or history. Of those who had been trained, when asked if their training prepared them adequately, the mean response was neutral. Ford and Hendrick suggested that graduate programs in counseling should provide more training on how to deal with sexual issues in counseling. A course that explores sexuality across the lifespan would be helpful to counselors in training (Ford & Hendrick, 2003). Counseling courses that have been offered in human sexuality have implemented a variety of teaching methods such as desensitization, role play, and discussion groups (Cross, 1991; Stayton, 1998; Weerakoon & Stiernborg, 1996).

Teaching methods.

Hilton (1997) suggested that both counselors and counselors in training should examine their own sexual issues and sexual histories. In this exploration, they should examine their childhood, adolescent, and adult experiences with sex and sexuality. Childhood experiences would include their parents' attitudes about sex, their own sexual feelings and behaviors, education they received regarding sex and sexuality, and any abuse or trauma experienced. To explore their adolescent experiences, they would examine their body image issues, sexual attitudes, sexual fantasies, and homosexual, heterosexual, and masturbatory sexual experimentation. While exploring their adulthood sexual experiences, they would explore their sexual behavior, their sexual and romantic relationships, how they communicate about sex, their sexual desires, and sexual satisfaction. Through this process, counselors and counselors in training would expand understanding of their own sexuality and the sexuality of others. In learning more about themselves, counselors would use this information to help others (Hilton, 1997).

A variety of teaching methods have been used in sexuality education. Research shows that some of the shorter and more intensive sexuality education programs for counselors do not have long lasting effects on their sexual attitudes and counseling skills (Anderson, 1986). Most of these programs use the implosion method, in which counselors are exposed to explicit sexual materials. Some believe this is not an effective teaching method and that it can result in disjointed or confused sexual attitudes among counselors (Anderson, 1986). Courses in human sexuality over a longer period of time that utilize educational resources, group discussion, role play, and videos tend to have longer lasting effects on counselors' sexual attitudes. Counselors who have received this type of sexuality education have been found to work more effectively with clients with sexual concerns than counselors who have not taken human sexuality courses (Anderson, 1986).

During these longer human sexuality courses, counselors are able to personally develop and become more comfortable with sexuality (Anderson, 1986). Some have proposed that individuals go through developmental stages in sexuality education programs. The developmental stages include: desensitization, sensitization, and incorporation. The desensitization stage involves being exposed to sexual material and becoming more comfortable with the material. The sensitization stage occurs when students explore their own sexuality and reach a point of sexual self-awareness. In the incorporation stage, students incorporate all that they have learned and are better equipped to help others (Anderson, 1986). For sexuality education programs to assure their students reach these stages, they must introduce students to factual sexual information. Students must be given the opportunity to explore their own sexual attitudes and behaviors during classroom exercises. Sexuality education programs must be sufficient in length to allow students time to grow, change, and develop (Anderson, 1986).

When Anderson (1986) first taught a course on human sexuality to counselors in training he used intense desensitization techniques in the first two class sessions. As a result, 20% of the students dropped out of the course. Anderson now incorporates desensitization throughout the entire course and gives the students control over how much they share about themselves. The method has been much more effective and allows students to develop at their own pace. Anderson had students evaluate which teaching methods they found to be most effective. They reported that live demonstrations that portray a counselor counseling a client with sexual concerns are the most helpful, followed by practicing taking a sexual history of a client. Lectures and guest speakers were rated as the next most effective, respectively, followed by practice sexual counseling sessions, journals, reading assignments, and class presentations. Based on his teaching experience and student evaluations, Anderson believes there are four stages of therapist comfort. Stage one requires students to explore their own sexuality and sexual issues. Stage two occurs when students become more aware of the potential various sexual issues of others. In the third stage, students begin to become more comfortable with sexuality in all areas of life. They are able to discuss sexuality more openly with others. The fourth stage involves students feeling more comfortable with clients sharing their sexual concerns (Anderson, 1986). Over the years, a variety of courses, workshops, and seminars have been created to help counselors develop in their sexuality education (Fyfe, 1980; Humphrey, 2000; Weerakoon & Stiernborg, 1996).

Courses, Workshops, Programs, and Seminars.

Fyfe (1980) developed courses and workshops meant to train counselors in human sexuality. These courses or workshops include five parts: sexual awareness, understanding of a sexual value system, dealing with sexuality in counseling, sexual dysfunctions and their

treatment, and sexual enhancement. During the sexual awareness portion of the training, counselors build on their existing sexual knowledge and examine their own sexual attitudes. It is important for counselors to explore their own sexual attitudes before working with clients' sexual issues. Understanding sexual value systems involves exploring the role values play in sex and sexuality. Counselors then learn how to deal with sexuality in counseling. During this segment of the course or workshop, they learn the importance of creating a safe and non-judgmental environment in which their clients can express their sexual concerns. Sex and sexuality are emotionally charged subjects, so counselors must be very sensitive to clients' needs when exploring clients' sexuality. During Fyfe's courses and workshops, counselors engage in role play to become more comfortable with the types of sexual concerns their clients might have. Next, counselors learn more about sexual dysfunctions and how to treat these dysfunctions. The final part of the course or workshop involves learning about sexual enhancement. Counselors learn a variety of enhancement models that can be used as tools to help enhance clients' sexual relationships. Counselors who complete this training find it to be helpful in increasing their knowledge and skills to better assist their clients with sexual issues (Fyfe, 1980).

Humphrey (2000) published a description of her experiences in creating and teaching a sexuality counseling course in a CACREP accredited counseling program entitled "Counseling for Sexuality Issues." The course objectives included: providing students with the opportunity to assess their own values and attitudes regarding sexuality and explore their own approach to sexuality counseling; educating students on theories and techniques associated with sexuality counseling; educating counselors in training with up to date information regarding human sexuality, STDs, and social and cultural influences on sexuality; exposing students to the current literature and research on human sexuality; and exploring ethical and professional issues

surrounding sexuality counseling (Humphrey). Humphrey utilized various teaching methods in the course, including: assigned readings, lecture, videos containing sexually explicit material, case vignettes, role plays, guest speakers, and class discussion. Students were required to complete journal reviews, research papers, two exams, and a final project on HIV/AIDS. Humphrey has made changes to the course over the past three years. After the course, many students reported feeling that they were very prepared when they counseled clients with sexual concerns. Humphrey's experience coincides with the previous literature by Weerakoon and Stiernborg (1996) explaining that a multimodal approach to teaching human sexuality is most effective.

Clinical Experience in Addressing Sexual Issues

To effectively provide counseling on sexual issues, healthcare professionals need both a basic understanding of human sexuality as well as clinical skills in addressing sexual issues with clients. These skills are different than other clinical skills that healthcare professionals receive in their training (Giami & Pacey, 2006). Although clinical experience in working with clients with sexual concerns is very important, there is very little research on this topic.

Harris and Hays (2008) found that marriage and family therapists' (MFTs) clinical experience was related to their willingness to initiate sexual discussions with clients. However, when compared to the other variables measured in the study, clinical experience was least likely to predict whether or not MFTs will initiate sexual discussions. Increased clinical experience did not result in increased perceived sexual knowledge in MFTs, and amount of clinical experience had no influence on MFTs' sexual comfort levels. Harris and Hays suggested that one explanation for why clinical experience had no relationship with sexual comfort level could be that some clinical experiences are not successful or positive.

A negative clinical experience in addressing sexual issues may result in a decrease in sexual comfort for the therapist. However, Anderson (2002) found in her study that the more years counselors had practiced, the greater their sexual comfort. Anderson indicated that this is likely due to the fact that the longer counselors have practiced; the more opportunity they had to work with clients who have sexual concerns or issues. This increased experience in turn leads to an increased level of comfort with sex and sexuality. It seems logical to assume that counselors are exposed to clients' sexual issues during their clinical training. Counselor training programs that expose students to more clinical experience with clients' sexual concerns may result in increased levels of sexual comfort and willingness to discuss sexual issues with clients. More research is needed in this area. Students who are exposed to clients with sexual concerns could benefit from supervisors who can teach them how to address these clients' concerns.

Supervision Experience Addressing Sexual Issues

Most sexual healthcare professionals and sexologists who focus specifically on clients' sexual problems have received both supervision and individual therapy. Supervision is very important for healthcare professionals who are working with clients' sexual health, due to the sensitive nature of the topic and the personal attitudes, values, and beliefs that can influence practice (Giami & Pacey, 2006). According to Bernard and Goodyear (2004), "Supervision is an intervention provided by a more senior member of a profession to a more junior member or members of that same profession. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the more junior person(s), monitoring the quality of professional services offered to the clients that she, he, or they see, and serving as a gatekeeper for those who are to enter the particular profession" (Bernard & Goodyear, 2004, p.8).

As stated earlier, Harris and Hays (2008) found that the best predictor for whether or not marriage and family therapists (MFTs) will initiate sexual discussion with their clients is their level of sexuality education and supervision experience with sexual issues. For MFTs, higher levels of sexuality education and supervision experience in addressing sexual issues lead to increased perceived sexual knowledge and increased sexual comfort levels. Therefore, if supervisors take the time to discuss sexual issues with their supervisee, the supervisee will feel more knowledgeable, comfortable, and confident in working with clients' sexual issues. Harris and Hays believe that sexuality education and supervision experience in addressing sexual issues are the foundation of MFT sexual comfort. MFTs gain knowledge through their sexuality education and supervision and as a result increase their sexual comfort. According to Harris and Hays, if MFTs do not receive sexuality education and supervision experience in addressing sexual issues, it is unlikely that their sexual comfort levels will increase. Unfortunately, Harris and Hays are the only researchers to have addressed how supervision experience influences counselors' sexual comfort, knowledge, and willingness to address sexual issues with clients. Though it is logical to assume that supervision experience that focuses on client sexual concern would benefit counselors, there is very little research on the topic. To further investigate Harris and Hays's findings, I measured counselors' supervision experience in my study.

Couples Therapy

For couples, the sexual relationship is often a reflection of the overall relationship. Issues in the relationship spill over into the sexual relationship (Meisel, 1977). If counselors are comfortable discussing sexual issues with couples, they can help the clients understand how sexual issues can affect the relationship and how relationship issues can impact the sexual relationship. Sex is an important part of a relationship, and it can affect the relationship in many

ways (Meisel, 1977). Cross (1991) believes that, as a society, we are all connected, so what one person does affects another person. In a relationship, the person most influenced by an individual's behavior is their partner. Communicating openly and effectively is important for individuals in relationships in order for each to have an understanding of their partner's thoughts and feelings. It is important for individuals to be both considerate and reliable for their partner. Jealousy, disloyalty, and infidelity can be detrimental for a relationship. Problems in a relationship affect not only the couple, but family and friends as well (Cross, 1991). There are a variety of sexual issues in a relationship that may arise in the course of couples counseling.

Sexual Issues and the Counselor's role.

Guldner and Guldner (1992) have identified issues that often surface during the course of couples counseling. Many couples have difficulty communicating their sexual interests, desires, and needs. The counselor can help facilitate open sexual communication. Some individuals may have problems seeing sex and sexuality as a source of pleasure. These individuals may view sex only as a function of reproduction. The counselor will assist them in exploring the early messages about sex and sexuality to which they may have been exposed. Another common concern for couples is the initiation of sex or negotiation that may occur with sex. Individuals in a couple have different desires in terms of frequency of sexual intercourse. The counselor can help these individuals learn how to initiate sex with the partner and say how to say no when one individual does not wish to engage in sex. Some couples have difficulty with their attitudes about sexual arousal. Many are frightened of becoming too aroused and losing control. Creating time and prioritizing sex into a couple's routine can also be challenging. Due to the many positive influences that sexual expression has on a relationship, it is important for couples to make time for their sexual relationship (Guldner & Guldner, 1992).

According to Guldner and Guldner (1992), many couples worry that their sexual relationship has become routine. Sexual enhancement can be used to help these couples. Some couples may experience difficulty negotiating the connection between affection and sexual expression, and other couples may have problems finding the privacy they need to attend to their sexual relationship. Many partners have conflicting sexual values and attitudes. Gender differences can also impact a couple's sexual relationship. Couples may experience sexual issues as a result of their lack of differentiation from one another. Extramarital affairs obviously can influence the sexual relationship. Some couples may have concerns of jealousy or possessiveness. Other sexual issues may be related to infertility or pregnancy. Many couples experience sexual issues as a result of aging or developmental changes. Illness or disability can impact the sexual relationship, as can compulsive sexual behavior. Past sexual abuse or trauma as well as sexual dysfunction all play a role in a couple's sexual relationship, as well. This is simply a basic summary of some of the possible sexual concerns that can emerge in couples counseling (Guldner & Guldner, 1992). It is important for counselors to be prepared to discuss these concerns with their clients. If a counselor is not willing to initiate discussion of a couple's sexual relationship, any one of these possible sexual problems may go untreated.

Creating a Safe Environment.

Estrada and Holmes (1999) conducted a study in which 15 married, heterosexual couples completed assessments before undergoing couples therapy. After eight couple's therapy sessions, each couple completed the same assessments and was interviewed about their therapeutic experiences. The assessments were used to measure each individual's marital consensus, satisfaction, cohesion, expression of affection and individual, child, and marital adjustment. Thirteen therapists provided the therapy in this study and each used the Integrative

Problem-Centered Therapy Model (IPCT), which utilizes components of behavioral, communication, and psychodynamic theory. IPCT involves a blend of individual, couples, and family therapy (Estrada & Holmes, 1999). Estrada and Holmes found that the couples felt therapy was most effective when their therapist played an active role in the discussion and was focused, empathetic, directive, provided an environment in which the couples felt safe to explore their relationship, and created a strong therapeutic alliance. Most couples have difficulties discussing sex with their partner and their therapist, so counselors must create an environment in which couples feel safe and comfortable discussing sexuality and sexual issues. Sex is often a sensitive issue that leaves individuals feeling vulnerable, but couples need to be open in their communication with one another. Counselors must approach the topic with ease. They need to be aware when couples begin discussing sexual issues to deflect the real issues that need to be addressed. Counselors must not allow couples to use the discussion of the sexual relationship as a forum for attacking and embarrassing the partner (Meisel, 1977). In order to create a safe environment in which clients feel comfortable discussing sexuality and sexual behaviors, healthcare professionals must be non-judgmental and sensitive to their clients. Healthcare professionals are able to create a safe and non-judgmental environment once they have an understanding of their own sexual attitudes, behaviors, and biases. In a more comfortable therapeutic environment, clients will be more open and honest (Andrews, 2000).

In my study, I surveyed counselors regarding the extent to which they discuss sexual issues with couples they are counseling. In addition, I measured their levels of sexual comfort, sexual attitudes, sexual knowledge, and supervision and training experience in addressing sexual issues. I chose to focus on counselors' work with couples because of the importance sex has in couples' relationships. I believe sexual issues should be explored and managed with both

partners present. Harris and Hays (2008) were two of the first researchers to empirically study therapists' willingness to discuss sexual issues with clients. I extended Harris and Hays' research by focusing on the extent to which counselors explore sexuality in couples counseling.

Summary

For this chapter, I reviewed several bodies of literature related to my study. In each section, I reviewed literature pertaining to healthcare professionals in general rather than counselors in particular due to the limited literature available on each topic regarding counselors. First, I reviewed research pertaining to healthcare professionals' willingness to discuss sexual issues with clients. I found that many healthcare professionals often avoid discussing sexual issues with clients due to their own discomfort, lack of time, and/or lack of knowledge or training (Haboubi & Lincoln, 2003; Hautamaki et al., 2007).

Next, I explored research on counselors' willingness to discuss sexual issues with clients. The research indicated that counselors may be avoiding the topic of sexuality because of their own discomfort, sexual attitudes, and/or a lack of knowledge or training (Anderson, 1986; Guldner & Guldner, 1992; Harris & Hays, 2008; Hilton, 1997). For this reason, I reviewed the literature on healthcare professionals' and counselors' sexual comfort, sexual attitudes, and sexual knowledge. These three variables seem to have a complex relationship. Research has suggests that these variables are correlated, but it is not clear if there is a cause and effect relationship between them (Anderson, 1986; Anderson, 2002; Arnold, 1980; Ducharme & Gill, 1990; Ford & Hendrick, 2003; Weerakoon & Stiernborg, 1996). Because sexual attitudes, comfort, and knowledge can each be addressed within education and/or training programs, I explored the literature concerning counselors' sexuality education and training.

I found that although teaching methods, courses, workshops, and models have been developed, there continues to be a lack of sexuality education and training for counselors and healthcare professionals (Bonner & Gendel, 1989; Cross, 1991; Ford & Hendrick, 2003; Frye, 1980; Hilton, 1997; Karlen & Moglia, Kirkpatrick, 1980; Mann & Wallace, 1975; Stayton, 1998; Weerakoon & Stirenborg, 1996). When examining the limited literature available on sexuality education and training, I found that clinical experience and supervision experience in addressing sexual issues may also play a role in counselors' sexual comfort and willingness to discuss sexual issues with clients (Anderson, 2002; Giami & Pacey, 2006; Harris & Hays, 2008).

In my study, I focused on counselors' sexual comfort and willingness to discuss sexual issues with couples. For this reason, I felt it was important to review literature concerning sexuality in regards to sex and couples therapy. The literature I found only reiterated the importance of addressing sexuality and sexual issues in couples counseling (Andrews, 2000; Estrada & Holmes, 1999; Guldner & Guldner, 1992; Masters & Johnson, 1970; Meisel, 1977).

CHAPTER THREE

Methodology

Purpose of the Study

The purpose of this study was to examine the factors that influence counselors' sexual comfort and willingness to discuss sexuality and sexual issues with couples they counsel. Therefore, I explored the relationship between the two dependent variables: counselors' sexual comfort and counselors' willingness to discuss sexual issues with couples they counsel. The independent variables measured were counselors': sexual attitudes, training and experience in discussing sexual issues, sexual knowledge, supervision experience addressing sexuality, and clinical experience discussing sexual issues. I sought to determine whether or not these variables had a relationship with counselors' sexual comfort and counselors' willingness to discuss sexual issues with couples they counsel. My expectation was that counselor educators would be able to utilize the findings to increase counselors' in training sexual comfort and willingness to discuss sexual issues with the couples they counsel.

Participants

The participants in this study were counselors who are members of the American Counseling Association (ACA). I purchased a email list of 2,000 randomly selected ACA members, from the over 40,000 total members of the ACA.

Characteristics of the Sample.

The sample in this study was 2,000 counselors, who were members of the American Counseling Association (ACA). Within this sample, only individuals who had worked with couples completed the survey. Of the 2,000 email addresses purchased from the ACA, only one was returned as "undeliverable" and was eliminated from the sample, limiting the sample to

1,999 counselors. A total of 304 participants returned the surveys, making the return rate 15.2%. Of these returned surveys, 224 were fully completed.

The majority of the participants were female (68.4%). This is consistent with the population of counselors in general. Table 1 includes descriptive e statistics for the participants' sex.

Table 1
Frequency Distribution of Participants by Sex

Sex	n	%
Female	175	68.4
Male	95	35.2
Total	270	100.0

Participants' age ranged from 25 to 75 years, with a mean of 48 ($SD=12$). Descriptive data for participants' age are in Table 2.

Table 2
Frequency Distribution of Participants by Age

Age	Frequency	%
25	1	0.3
26	2	0.7
27	5	1.6
28	6	2.0
29	10	3.3
30	7	2.3
31	6	2.0
32	5	1.6
33	2	0.7
34	9	3.0
35	3	1.0
36	8	2.6
37	2	0.7
38	4	1.3
39	4	1.3
40	10	3.3
41	5	1.6
42	5	1.6
43	7	2.3
44	4	1.3
45	5	1.6
46	3	1.0
47	4	1.3
48	1	0.3
49	8	2.6
50	7	2.3
51	6	2.0
52	11	3.6
53	5	1.6
54	8	2.6
55	9	3.0
56	13	4.3
57	15	4.9
58	16	5.3
59	11	3.6
60	8	2.6
61	7	2.3
62	4	1.3
63	3	1.0
64	6	2.0
65	1	0.3
67	2	0.7

Table 2 Continued

Age	Frequency	%
68	4	1.3
69	2	0.7
70	1	0.3
71	1	0.3
75	1	0.3
Total	304	100.0

Participants were asked to rate the strength of their religion on a scale of 1-5. A response of 1 was considered weak, 3 was moderate, and 5 was strong. Of the participants, 19.2% reported a weak strength of religion, 10.3% reported their strength of religion between weak and moderate. Of the participants, 25.8% reported their strength of religion as moderate, while 15.1% reported theirs between moderate and strong. There were 29.5% of participants that reported their strength of religion as strong. A frequency distribution of participants' strength of religion can be found in Table 3.

Table 3

Frequency Distribution of Participants by Strength of Religion

Strength of Religion	n	%
1 Weak	52	19.2
2	28	10.3
3 Moderate	70	25.8
4	41	15.1
5 Strong	80	29.5
Total	289	100.0

Participants were asked to identify their sexual orientation as bisexual, heterosexual, homosexual, or other. The majority of participants identified themselves to be heterosexual (89.3%). Bisexuals made up 4.4% of the sample, while 5.2% identified themselves as homosexuals, and 1.1% identified themselves as other. A frequency distribution of the sexual orientation of participants can be found in Table 4.

Table 4
Frequency Distribution of Participants by Sexual Orientation

Sexual Orientation	n	%
Bisexual	12	4.4
Heterosexual	242	89.3
Homosexual	14	5.2
Other	3	1.1
Total	289	100.0

Participants' years of experience as counselors ranged from 0 to 43 years, with a mean of 12 ($SD=10$). Descriptive statistics of participants' years of practice are listed in Table 5.

Table 5
Frequency Distribution of Participants by Years of Practice

Years of Practice	Frequency	%
0	2	0.7
1	21	6.9
2	28	9.2
3	16	5.3
4	19	6.2
5	13	4.3
6	9	3.0
7	8	2.6
8	9	3.0
9	8	2.6
10	12	3.9
11	8	2.6
12	13	4.3
13	2	0.7
14	3	1.0
15	14	4.6
16	6	2.0
17	5	1.6
18	1	0.3
19	3	1.0
20	10	3.3
21	2	0.7
22	5	1.6
23	4	1.3
24	3	1.0
25	6	2.0
26	1	0.3
27	2	0.7
28	4	1.3
29	2	0.7
30	11	3.6
31	2	0.7
33	2	0.7
34	2	0.7
35	8	2.6
37	1	0.3
40	2	0.7
43	1	0.3
Total	304	100.0

Participants were asked about their current practice settings and were asked to choose among agency, hospital, private practice, school, and other. Of the participants, 27.2% reported working in an agency, 4.5% in a hospital, 38.1% in a private practice, 16.4% are school counselors, and 13.8% are employed in some other setting. Frequencies of participants' practice settings are listed in Table 6.

Table 6
Frequency Distribution of Participants by Practice Setting

Practice Setting	n	%
Agency	73	27.2
Hospital	12	4.5
Private Practice	102	38.1
School	44	16.4
Other	37	13.8
Total	286	100.0

Participants were asked about which types of licenses that they most identify. They were given the following choices: LMFT, LPC, LPC and LMFT, not licensed, and other. Most participants self-identified as LPCs (45.9%). LMFTs made up of 3.0% of the sample, while 4.4% identified as LPCs and LMFTs and 28.9% as other. Of counselors in the sample, 17.8% were not licensed. A frequency distribution of participants' type of license is shown in Table 7.

Table 7
Frequency Distribution of Participants by Type of License

Type of License	n	%
LMFT	8	3.0
LPC	124	45.9
LPC and LMFT	12	4.4
Not Licensed	48	17.8
Other	78	28.9
Total	288	100.0

Participants were asked to identify which graduate specializations they completed in their graduate counseling programs. The majority of participants specialized in clinical mental health/community counseling (61.6%). Of the participants, 4.2% specialized in addiction counseling, and 4.2% specialized in career counseling. Participants specializing in marriage, couple, and family counseling comprised of 13.5% of the sample, while those specializing in school counseling made up 10.1%. Finally, 6.3% of the participants specialized in student affairs and college counseling. Descriptive statistics of participants' graduate specializations are listed in Table 8.

Table 8

Frequency Distribution of Participants by Graduate Specialization

Graduate Specialization	n	%
Addiction	10	4.2
Career	10	4.2
Clinical Mental Health/Community	146	61.6
Marriage, Couple, and Family	32	13.5
School	24	10.1
Student Affairs and College	15	6.3
Total	255	100.0

Participants were asked to identify their relationship status. Of the participants, 10.4% identified as being divorced. Participants who were in committed relationships made up 13.8% of the sample, while married participants made up 62.8% of the sample. Of the participants, 11.2% were single and 1.9% widowed. A frequency distribution of participants' relationship statuses can be found in Table 9.

Table 9

Frequency Distribution of Participants by Relationship Status

Relationship Status	n	%
Divorced	28	10.4
In a Committed Relationship	37	13.8
Married	169	62.8
Single	30	11.2
Widowed	5	1.9
Total	287	100.0

General Research Question

To what extent are counselors discussing sexual issues with couples they are counseling?

What factors influence the extent to which the counselors are comfortable with or willing to discuss sexuality with couples they counsel?

Specific Research Questions

Research Question 1: Is there a relationship between counselors' sexual comfort and the extent to which they discuss sex with couples whom they are counseling?

Research Question 2: Is there a relationship between counselors' sexual comfort and their sexual attitudes, training experience in sexual issues, sexual knowledge, supervision experience addressing sexuality, and clinical experience with sexual issues?

Research Question 3: Is there a relationship between the extent to which counselors discuss sexual issues with couples they counsel and

the following factors: counselors' sexual attitudes, training experience in sexual issues, sexual knowledge, supervision experience addressing sexuality, and clinical experience with sexual issues?

Research Question 4: Which influencing variables (sexual attitudes, training experience in sexual issues, sexual knowledge, supervision experience addressing sexuality, and clinical experience with sexual issues) predict a counselor's comfort level with sexuality?

Research Question 5: Which influencing variables (sexual attitudes, training experience in sexual issues, sexual knowledge, supervision experience addressing sexuality, and clinical experience with sexual issues) predict the extent to which counselors discuss sexual issues with couples they counsel?

Research Question 6: Is there a relationship between the sexual comfort of counselors and counselors' sex, age, strength of faith, sexual orientation, number of years practicing, practice setting, type of license, type of graduate specialization, or relationship status?

Research Question 7: Is there a relationship between the extent to which counselors discuss sexual issues with couples they counsel and counselors' sex, age, strength of faith, sexual orientation, number of years practicing, practice setting, type of license, type of graduate specialization, or relationship status?

Variables

Independent Variables.

I examined the following independent variables in this study: Counselors' (1) sexual comfort, (2) sexual attitudes, (3) training experience in sexual issues, (4) sexual knowledge, (5) supervision experience addressing sexuality, (6) clinical experience with sexual issues (7) sex, (8) age, (9) strength of faith, (10) sexual orientation, (11) number of years practicing, (12) practice setting, (13) type of license (LPC, LMFT, both, or other), (14) type of graduate specialization (addiction; career; clinical mental health/community; marriage, couple, and family; school; or student affairs and college), and (15) relationship status. Part 1 of the *Sexual Comfort Instrument* (SCI; Hedgepeth, 1988) was used to measure the level of sexual comfort in counselors. The *Brief Sexual Attitudes Scale* (BSAS; Hendrick, Hendrick, & Reich, 2006) was used to measure sexual attitudes. Training experience in sexual issues was measured using the demographic section of the questionnaire and by the *Sexuality Education and Supervision Scale* (SESS; Harris & Hays, 2008). Sexual knowledge was measured using *The Miller-Fisk 24-Item Sexual Knowledge Questionnaire* (SKQ; Gough, 1974). Supervision experience addressing sexuality was measured using the *Sexuality Education and Supervision Scale* (SESS; Harris & Hays, 2008). Clinical experience with sexual issues was measured using the *Clinical Experience Scale* (CES; Harris & Hays, 2008). I created a demographic form to collect data on the following variables: sex, age, strength of faith, sexual orientation, number of years practicing, practice setting, type of license, type of graduate program, and relationship status.

Dependent Variables.

The dependent variables in the study were counselors' sexual comfort and the extent to which counselors discuss sex with couples they are counseling. As stated, Part 1 of the *Sexual*

Comfort Instrument (SCI; Hedgepeth, 1988) was used to measure the level of sexual comfort in counselors. I modified the *Sexuality Discussions with Clients Scale* (SDCS, Harris & Hays, 2008) so that it measured specifically the extent to which counselors discuss sexual issues with couples.

Instrumentation

Instrument:	Author:	Measured:
Demographic Data	Wieck, 2009	Counselors' sex, age, strength of faith, sexual orientation, number of years practicing, practice setting, type of license, type of graduate program, and relationship status
24-Item Miller-Fisk Sexual Knowledge Questionnaire	Gough, 1974	Sexual Knowledge
Sexual Comfort Instrument	Hedgepeth, 1988	Individuals' comfort level with sexuality
Brief Sexual Attitude Scale	Hendrick, Hendrick, & Reich, 2006	Individuals' sexual attitudes

Sexuality Education Scale	Harris & Hays, 2008	The types of sexuality education therapists received in their graduate training and after graduating
Experience in Supervision Scale	Harris & Hays, 2008	The extent to which sexuality issues were discussed during the counselor's supervision experience
Clinical Experience Scale	Harris & Hays, 2008	The amount of clinical experience a therapist has had with clients with sexual issues
Sexuality Discussion with Clients Scale	Harris & Hays, 2008	Therapists' willingness to engage in sexuality-related discussions with their clients.

24-Item Miller-Fisk Sexual Knowledge Questionnaire

In 1969, a *49-item Miller-Fisk Sexual Knowledge Questionnaire* was created by psychiatrist Warren Miller and ob-gyn Norman Fisk. The questionnaire consists of items regarding reproduction, contraception, menstruation, sex drive, and fertility (Gough, 1974). A study was conducted to discover whether a shortened version of the questionnaire could be

created that would include the majority of the content and remain a reliable measurement tool. A *24-item Miller Fisk Sexual Knowledge Questionnaire* was created and completed by different samples. One sample consisted of 209 males and 146 female UC Berkeley college students. The second sample consisted of 78 males of whom 25 were adults and 44 were students, and 100 females of whom 60 were adults and 40 were students (Gough, 1974). Every point-biserial coefficient was statistically significant at the .01 level. The researchers concluded that the internal consistency of the questionnaire was sufficient. In a sample of 355 males and females, odd-even reliability coefficients were measured. The corrected coefficients were .70 for the males, .62 for the females, and .67 for the entire sample. These corrected coefficients were found to be sufficient for a questionnaire being used for research. The males' mean was 15.51, $SD = 3.77$ on the *24-item Miller Fisk Sexual Knowledge Questionnaire*. The females' mean was 16.55, $SD = 3.47$, and the entire sample's mean was 15.94, $SD = 3.69$. The difference found between females and males of 1.04 resulted in a t ratio of 2.68, $p \leq .01$ (Gough, 1974).

The *24-item Miller Fisk Sexual Knowledge Questionnaire* was found to cover the same material as the 49-item questionnaire and maintain an acceptable internal consistency when used with college students and adults. The questionnaire takes around 10 minutes to complete (Gough, 1974). I used the 24-item questionnaire in my study to measure counselors' sexual knowledge.

Sexual Comfort Instrument

In her dissertation, Hedgepeth (1988) created the *Sexual Comfort Instrument (SCI)* to measure an individual's comfort level with sexuality. Hedgepeth measured the reliability and validity of the *Sexual Comfort Instrument (SCI)* and found both to be strong ($t = 7.37$, $p < .0005$;

test-retest $r = .90$; Cronbach's $\alpha = .93$). Hedgepeth used Graham's and Smith's (1984) definition of sexual comfort as a basis to measure sexual comfort.

The SCI consists of 66 Likert-type questions and has three parts. Part I of the SCI measures personal and general comfort with sexuality. Hedgepeth (1988) states that the high reliability and validity of Part I mean it can be used as a separate measure of sexual comfort. Therefore it can be used to measure the sexual comfort of individuals other than sex educators. Other researchers have used Part I of the SCI to measure the sexual comfort of counselors (Anderson, 2002; Roche, 1998). For the purpose of this study, Part I of the SCI was used to measure counselors' sexual comfort. Part I contains 18 items regarding personal and general sexual comfort. *The Personal Comfort Scale (PCS)* and *General Comfort Scale (GCS)* make up the two sections of Part I of the SCI. Of those surveyed, 96 individuals completed the SCI. Based on the analysis of the returned surveys, Hedgepeth found Cronbach's alpha for the PCS to be .82. The Cronbach's alpha for the GCS was .83. Hedgepeth used a sample of 55 sex educators in training and retested them one month later. Hedgepeth found a test-retest reliability of .80 for the PCS and .85 for the GCS. Lower scores on the SCI indicate greater comfort with sexuality. I used this instrument in my study to measure counselors' sexual comfort.

The Brief Sexual Attitudes Scale

The *Brief Sexual Attitudes Scale* was created to provide a shorter version of the *Sexual Attitudes Scale* that consisted of 43 items (Hendrick et al., 2006). In addition, the authors wanted to update the scale and remove outdated items that were no longer applicable. The original *Sexual Attitudes Scale* was created to assess individuals' sexual attitudes on multiple dimensions. The original instrument consisted of four subscales: Permissiveness (casual sexuality), Sexual Practices (responsible, tolerant sexuality), Communion (idealistic sexuality), and Instrumentality

(biological, utilitarian sexuality). The original *Sexual Attitudes Scale* has been used successfully in a variety of research studies since the 1980s. In creating the *Brief Sexual Attitudes Scale*, the authors changed the subscales to Permissiveness, Birth Control, Communion, and Instrumentality (Hendrick et al., 2006).

The reliability and validity were measured using three different samples. The first sample consisted of 674 undergraduates at a Southwestern university. The alphas for the subscales were found to be similar to the alphas of the original scale and were found to be appropriate for brief scales. The alphas for the four subscales were as follows: Permissiveness = 0.93, Birth Control = 0.84, Communion = 0.71, and Instrumentality = 0.77. The *Brief Sexual Attitudes Scale* correlates with other scales in a way that is consistent with the original *Sexual Attitudes Scale* (Hendrick et al., 2006).

The second sample was made up of 528 undergraduate students enrolled in an Introduction to Psychology course in a large Southwestern university. In this study, the researchers compared the long and short versions of the *Sexual Attitudes Scale*. The *Brief Sexual Attitudes Scale* had a Goodness of Fit Index (GFI) of 0.98, a GFI adjusted for degrees of freedom (AGFI) of 0.96, a root mean square of error of approximation (RMSEA) of 0.5, a Bentler's Comparative of Fit Index (CFI) of 0.99 and $[X.Sup.2] (21,528) = 44.7$. The chi square difference test found the difference between the scales to be highly significant ($p < 0.001$). The *Brief Sexual Attitude Scale* provided a better model fit than the original *Sexual Attitude Scale*. The alphas for the four subscales were as follows: Permissiveness = 0.95, Birth Control = 0.87, Communion = 0.79, and Instrumentality = 0.80. The correlations between the *Brief Sexual Attitudes Scale* and other scales were comparable to the correlations between the original *Sexual Attitudes Scale* and

other scales. These results show that the similarities between the two scales cannot be due to chance factors occurring in a single study (Hendrick et al., 2006).

The third sample was made up of 518 undergraduate students enrolled in an Introduction to Psychology course in a large Southwestern university. The alphas for the four subscales were as follows: Permissiveness = 0.95, Birth Control = 0.88, Communion = 0.73, and Instrumentality = 0.77. The subscale intercorrelation was measured and found to be 0.20 or lower. Test-retest reliability was measured and the correlations for the subscales were Permissiveness = 0.92, Birth Control = 0.57, Communion = 0.86, and Instrumentality = 0.75 (Hendrick et al., 2006).

The *Brief Sexual Attitudes Scale* is a 23-item measure. The scale is made up of four subscales. The Permissiveness subscale consists of 10 items, Birth Control contains three items. Five items make up the Communion and the Instrumentality subscales (Hendrick et al., 2006). Participants receive four subscale scores, based on the mean score for a particular subscale. An overall scale score is not used. I used the *Brief Sexual Attitude Scale* to measure counselors' sexual attitudes.

Sexuality Education Scale

Harris and Hays (2008) created the *Sexuality Education Scale* to measure the types of sexuality education therapists received in their graduate training and after graduating. The *Sexuality Education Scale* is a self-report measure that contains seven items. The scale consists of questions regarding the respondents' levels of sexuality education. The scale is scored by giving one point for every type of sexuality education the respondent has participated in. A higher score signifies a higher level of sexuality education (Harris & Hays, 2008). I used this scale in my study to measure counselors' sexuality education. There are no reliability or validity data on this scale. However, the scale was used successfully by Harris and Hays.

Experience in Supervision Scale

Harris and Hays (2008) created the *Experience in Supervision Scale* to measure the extent to which sexuality issues were discussed during respondents' supervision experience. The *Experience in Supervision Scale* contains five questions. The higher the score, the more experience the respondent has in discussing sexuality issues in the supervisory relationship (Harris & Hays, 2008). I used this scale in my study to measure counselors' experience discussing sexual issues in supervision. This scale was used successfully by Harris and Hays, as well. There is no reliability or validity data for this scale.

Clinical Experience Scale

Harris and Hays (2008) developed the *Clinical Experience Scale* to measure the amount of clinical experience a therapist has with clients with sexual issues. It is a 5-item self-report measure in which higher scores indicate more clinical experience with clients with sexual issues. There is no reliability or validity data for this scale, though it was used successfully by Harris and Hays. I used this scale in my study to measure counselors' clinical experience with sexual issues.

Sexuality Discussion with Clients Scale

Harris and Hays (2008) created the *Sexuality Discussion with Clients Scale* to measure therapists' sexuality-related discussions with clients. The *Sexuality Discussion with Clients Scale* is a self-report Likert-type measure containing nine items that assess the extent to which therapists have sexual discussions with their clients. The higher a score, the more willing a therapist is to initiate sexuality discussions with his or her clients (Harris & Hays, 2008). I used this scale in my study to measure counselors' willingness to discuss sexual issues with couples. Anytime the word "client(s)" was used in the scale, I substituted it with the word "couple(s)".

There is no reliability or validity data for this scale. Harris and Hays used the scale successfully in their study.

Permission to use these scales can be found in Appendix A.

Panel Review of Instruments

I sent my survey to an expert panel to receive feedback regarding the time it takes to complete the survey, how easy it is to take the survey, and what, if any, information is missing from the survey. My expert panel consisted of five counselor educators from CACREP accredited counseling programs with PhDs in counselor education or counseling-related fields. Based on the feedback I received from my expert panel, I made the following changes to my demographic data section: I alphabetized the options listed to avoid showing biases; I added a line on which participants who marked “other” could specify their answers; I put options in bullet format to avoid confusion; I decided to ask participants to list specific age and number of years practicing to be able to report the mean; I added another option for participants to indicate type of license so that I could gain more information; I added community to the clinical mental health option for those who are not familiar with the recent CACREP change in the specialization name; I added divorced and widowed as options for relationship status.

As a result of the expert panel’s feedback, I moved the *24-Item Miller-Fisk Sexual Knowledge Questionnaire* (SKQ; Gough, 1974) to the end of the survey because it is the longest scale and could have discouraged participants from continuing. It also did not measure the main variable in my study. I made the *Sexual Comfort Instrument* (SCI; Hedgepeth, 1988) the first scale after the demographic data, followed by the *Sexual Discussion with Couples Scale* (SDCS, Harris & Hays, 2008) because sexual comfort and willingness to discuss sexual issues with couples are the dependent variables in my study. I shortened the directions for the *Sexual*

Discussion with Couples Scale (SDCS, Harris & Hays, 2008). I added directions to the *24-Item Miller-Fisk Sexual Knowledge Questionnaire* (SKQ; Gough, 1974). For the *Sexual Comfort Instrument* (SCI; Hedgepeth, 1988), I added number items to represent the participants' responses in Section A and Section C. In addition, I changed the directions to reflect this change. I changed the directions for *The Sexuality Education Scale* (SESS; Harris & Hays, 2008), *Experience in Supervision Scale* (SESS; Harris & Hays, 2008), and *Clinical Experience Scale* (CES; Harris & Hays, 2008) to make them more clear.

Based on the feedback I received from the expert panel, the survey took between 10-25 minutes to complete. This was deemed appropriate for use in my study.

Data Collection

I purchased a randomly selected email list of 2,000 ACA members from the over 40,000 members of the ACA. A questionnaire was sent to the counselors using Qualtrics™, a web-based survey software, that measured counselors': demographic data, sexual comfort, willingness to discuss sexual issues with couples, sexual attitudes, sexual knowledge, sexuality education, supervision experience addressing sexuality, and clinical experience with sexual issues. I sent each ACA member on this list an email with a link to an electronic version of the questionnaire. Those who choose to complete the survey were my research participants. After one week, I sent a follow-up email requesting that the ACA members complete the questionnaire if they had not yet done so.

I hoped to have a 15% return on the surveys, which is approximately 300 surveys. A 15% return rate would allow for minimum sampling errors overall. My actual percentage of returns on the surveys was 15.2%. Of the 2,000 members I surveyed, 304 participants returned the survey. Of the surveys that were returned, 224 were fully completed, or 73.6%.

I used survey research design to obtain my data. A benefit of survey design is that it allows the researcher to make generalizations about a population from a sample of that population (Babbie, 1990). Inferences can be made about that population based on the characteristics, beliefs, behaviors, and attitudes found in the sample. The survey was cross-sectional, or only collected at one point in time. The survey was an Internet survey that was distributed by Qualtrics™, an online survey and data collection service.

Prior to sending out the questionnaire, I submitted the proposal for my study, along with the questionnaire, to the University of New Orleans Committee for the Protection of Human Subjects Research (IRB), to receive permission to proceed with the study. I received permission from the University of New Orleans Committee for the Protection of Human Subjects Research (IRB) to conduct my study (see Appendix B). I then submitted my proposal, my IRB approval letter, and my questionnaire to the American Counseling Association (ACA) in order to receive approval to purchase an email list of ACA members. I received approval (see Appendix C) and purchased an email list of 2,000 ACA members.

I sent an email requesting participation in the survey (see Appendix D) to 2,000 counselors who were members of the ACA. The email included a link to the questionnaire on Qualtrics.com. A week after the emails were sent, I sent a follow-up email requesting that counselors participate in the study, if they had not already done so. One week later, I sent a final follow-up email requesting participation. Participation was anonymous and voluntary.

Data Analysis Procedure

I analyzed the data using descriptive statistics, correlation, comparative, and a multiple regression analysis using stepwise linear regression. Stepwise linear regression enables the researcher to sort through each independent variable and reveal which independent variable has

the greatest statistically significant influence on the dependent variable (Spicer, 2005). The data were analyzed using the SPSS 15.0 statistical package.

Because I measured so many correlations, I used a conservative alpha level of 0.01 for significance.

Each research question is listed below along with the statistical analysis that was performed on each question.

Research Question 1: Is there a relationship between counselors' sexual comfort and the extent to which they discuss sex with couples they are counseling?

Data Analysis: A Pearson-product moment correlation was calculated using the participants' sexual comfort scores and the participants' sexuality discussions with couples' scores.

Research Question 2: Is there a relationship between counselors' sexual comfort and their sexual attitudes, training experience in sexual issues, sexual knowledge, supervision experience addressing sexuality, and clinical experience with sexual issues?

Data Analysis: A Pearson-product moment correlation was calculated using the participants' sexual comfort scores and sexual attitude scores.

Data Analysis: A Pearson-product moment correlation was calculated using the participants' sexual comfort scores and training experience in sexual issues scores.

Data Analysis: A Pearson-product moment correlation was calculated using the participants' sexual comfort scores and sexual knowledge scores.

Data Analysis: A Pearson-product moment correlation was calculated using the participants' sexual comfort scores and supervision experience addressing sexuality scores.

Data Analysis: A Pearson-product moment correlation was calculated using the participants' sexual comfort scores and clinical experience with sexual issues scores.

Research Question 3: Is there a relationship between the extent to which counselors discuss sexual issues with couples they counsel and counselors' sexual attitudes, training experience in sexual issues, sexual knowledge, supervision experience addressing sexuality, and clinical experience with sexual issues?

Data Analysis: A Pearson-product moment correlation was calculated using the participants' willingness to discuss sexual issues with couples they counsel scores and sexual attitude scores.

Data Analysis: A Pearson-product moment correlation was calculated using the participants' willingness to discuss sexual issues with couples they counsel scores and training experience in sexual issues scores.

Data Analysis: A Pearson-product moment correlation was calculated using the participants' willingness to discuss sexual issues with couples they counsel scores and sexual knowledge scores.

Data Analysis: A Pearson-product moment correlation was calculated using the participants' willingness to discuss sexual issues with couples they counsel scores and supervision experience addressing sexuality scores.

Data Analysis: A Pearson-product moment correlation was calculated using the participants' willingness to discuss sexual issues with couples they counsel scores and clinical experience with sexual issues scores.

Research Question 4: Which influencing variables (sexual attitudes, training experience in sexual issues, sexual knowledge, supervision experience addressing sexuality, and clinical experience with sexual issues) predict a counselor's comfort level with sexuality?

Data Analysis: A stepwise linear regression was conducted to determine whether one or more of the variables (sexual attitudes, training experience in sexual issues, sexual knowledge, and supervision experience addressing sexuality) can adequately predict counselor sexual comfort level.

Research Question 5: Which influencing variables (sexual attitudes, training experience in sexual issues, sexual knowledge, supervision experience addressing sexuality, and clinical experience with sexual issues) predict the extent to which counselors will discuss sexual issues with couples they counsel?

Data Analysis: A stepwise regression was conducted to conclude whether one or more of the variables (sexual attitudes, training experience in sexual issues, sexual knowledge, supervision experience addressing sexuality, and clinical experience with sexual issues) can adequately predict counselors' willingness to discuss sexual issues with couples they counsel.

Research Question 6: Is there a relationship between the sexual comfort of counselors and counselors' sex, age, strength of faith, sexual orientation, number of years practicing, practice setting, type of license, type of graduate program, or relationship status?

Data Analysis: A Chi square measure of assessment was calculated using the participants' sexual comfort scores and their sex.

Data Analysis: A Pearson-product moment correlation was calculated using the participants' sexual comfort scores and their ages.

Data Analysis: A Pearson-product moment correlation was calculated using the participants' sexual comfort scores and their strength of faith.

Data Analysis: A Chi square measure of assessment was calculated using the participants' sexual comfort scores and their sexual orientation.

Data Analysis: A Pearson-product moment correlation was calculated using the participants' sexual comfort scores and the number of years they have been practicing.

Data Analysis: A Chi square measure of assessment was calculated using the participants' sexual comfort scores and their practice setting.

Data Analysis: A Chi square measure of assessment was calculated using the participants' sexual comfort scores and their type of license.

Data Analysis: A Chi square measure of assessment was calculated using the participants' sexual comfort scores and the type of graduate specialization they studied in their graduate work.

Data Analysis: A Chi square measure of assessment was calculated using the participants' sexual comfort scores and their relationship status.

Research Question 7: Is there a relationship between the extent to which counselors discuss sexual issues with couples they counsel and counselors' sex, age, strength of faith, sexual orientation, number of years practicing, practice setting, type of license, type of graduate program, or relationship status?

Data Analysis: A Chi square measure of assessment was calculated using the participants' extent to which they discuss sexual issues with couples they counsel scores and their sex.

Data Analysis: A Pearson-product moment correlation was calculated using the participants' extent to which they discuss sexual issues with couples they counsel scores and their ages.

Data Analysis: A Pearson-product moment correlation was calculated using the participants' extent to which they discuss sexual issues with couples they counsel scores and their strength of faith.

Data Analysis: A Chi square measure of assessment was calculated using the participants' extent to which they discuss sexual issues with couples they counsel scores and their sexual orientation.

Data Analysis: A Pearson-product moment correlation was calculated using the participants' extent to which they discuss sexual issues with couples they counsel scores and the number of years they have been practicing.

Data Analysis: A Chi square measure of assessment was calculated using the participants' extent to which they discuss sexual issues with couples they counsel scores and their practice setting.

Data Analysis: A Chi square measure of assessment was calculated using the participants' extent to which they discuss sexual issues with couples they counsel scores and their type of license.

Data Analysis: A Chi square measure of assessment was calculated using the participants' extent to which they discuss sexual issues with couples they counsel scores and the type of graduate specialization they studied in their graduate work.

Data Analysis: A Chi square measure of assessment was calculated using the participants' extent to which they discuss sexual issues with couples they counsel scores and their relationship statuses.

CHAPTER FOUR

Results

Purpose of the Study

The purpose of this study was to examine the factors that influence counselors' sexual comfort and willingness to discuss sexuality and sexual issues with couples they are counseling. Therefore, I explored the relationship between the two dependent variables: counselors' sexual comfort and counselors' willingness to discuss sexual issues with couples they counsel. The independent variables were counselors': sexual attitudes, training and experience in discussing sexual issues, sexual knowledge, supervision experience addressing sexuality, and clinical experience discussing sexual issues. I sought to determine if these variables had a relationship with counselors' sexual comfort and counselors' willingness to discuss sexual issues with couples they counsel. My expectation was that counselor educators would be able to utilize the findings to increase counselors' in training sexual comfort and willingness to discuss sexual issues with the couples they counsel.

Analysis of Research Questions

Research Question 1.

Research Question 1 asked if there was a relationship between counselors' sexual comfort and the extent to which they discuss sex with couples they are counseling. Counselors' sexual comfort was measured by Part 1 of the *Sexual Comfort Instrument* (SCI; Hedgepeth, 1988), which consisted of items 10-27 of the survey. The extent to which counselors discuss sex with couples was measured by the modified *Sexuality Discussions with Clients Scale* (SDCS, Harris & Hays, 2008), which consisted of items 28-29 in the survey. A Pearson product moment correlation was calculated using the participants' sexual comfort scores and the participants'

sexuality discussions with couples scores. The results of these correlations are presented in Table 10.

Table 10
Correlation Results of Participants' Scores of Sexual Comfort and Sexuality Discussion with Couples

		Sexual Comfort Scores
Sexuality Discussion with Couples Scores	Pearson Correlation	-.40*
	Sig. (2-tailed)	.00

n=213

*Correlation is significant beyond the 0.01 level

The lower the Sexual Comfort Score, the greater the sexual comfort.

The higher the Sexuality Discussion with Couples Score, the more willing therapists are to initiate sexuality discussions with couples.

A negative correlation was found ($r = -.40, p < .01$) between the participants' sexual comfort scores and their sexual discussion with couples scores. The relationship was significant beyond the .01 level. A negative relationship indicates that as sexual comfort scores increase sexuality discussions with couples scores decrease. Therefore, sexual comfort is significantly related to sexuality discussion with couples. Sexual Comfort scores are reverse coded, therefore the relationship between participant's sexual comfort and sexuality discussion with couples is actually positive. This indicates that the greater counselors' sexual comfort, the more willing they are to discuss sexuality with couples they counsel. In this relationship, $r = -.40$, the $r^2 = .16$, which means 16% of the variance in the extent to which counselors discuss sexual issues with couples is due to counselors' sexual comfort. These results are statistically significant.

Research Question 2.

Research Question 2 asked whether there was a relationship between counselors' sexual comfort and their sexual attitudes, training experience in sexual issues, sexual knowledge, supervision experience addressing sexuality, and clinical experience with sexual issues.

Counselors' sexual comfort was measured by Part 1 of the *Sexual Comfort Instrument* (SCI; Hedgepeth, 1988), which consisted of items 10-27 of the survey. Counselors' sexual attitude was measured by the *Brief Sexual Attitudes Scale* (BSAS; Hendrick, Hendrick, & Reich, 2006), which was made up of items 57-79. The *Brief Sexual Attitudes Scale* (BSAS; Hendrick, Hendrick, & Reich, 2006) consisted of four subscales: Permissiveness (which was measured by items 57-66), Birth Control (measured by items 67-69), Communion (measured by items 70-74), and Instrumentality (measured by items 75-79). The lower the sexual attitude subscale score, the greater that particular sexual attitude. Pearson product moment correlations were calculated using the participants' sexual comfort scores and sexual attitude scores. The results are presented in Table 11.

Table 11
Correlation Results of Participants' Scores of Sexual Comfort and Sexual Attitude

Sexual Attitude Scores		Sexual Comfort Scores
Permissiveness	Pearson Correlation	.13
	Sig. (2-tailed)	.09
Birth Control	Pearson Correlation	.13
	Sig. (2-tailed)	.09
Communion	Pearson Correlation	.19*
	Sig. (2-tailed)	.00
Instrumentality	Pearson Correlation	-.10
	Sig. (2-tailed)	.15

n=181 (Permissiveness)
n=191 (Birth Control)
n=190 (Communion)
n=189 (Instrumentality)
*Correlation is significant at the 0.01 level
The lower the Sexual Comfort Score, the greater the sexual comfort.
The lower the Sexual Attitude Subscale Score, the greater that particular sexual attitude.

No correlation was found ($r = .13$, *ns*) between the participants' sexual comfort scores and the participants' permissiveness scores. According to the analysis, sexual comfort is not related

to sexual attitudes towards permissiveness (casual sexuality). There is not a significant relationship between these variables.

No correlation was found ($r = .13, ns$) between the participants' sexual comfort scores and the participants' birth control scores. According to the analysis of this study, sexual comfort is not related to sexual attitudes toward birth control or more responsible sexual practices. There is not a significant relationship between these variables.

A small correlation was found ($r = .19, p < .01$) between the participants' sexual comfort scores and their communion scores. The relationship was significant at the .01 level. A relationship indicates that as sexual comfort scores decrease (and sexual comfort increases), communion scores decrease (and sexual attitude regarding communion increases). Therefore, sexual comfort is significantly related to sexual attitudes towards communion or idealistic sexuality. In this relationship, an $r = .19$, the $r^2 = .04$, which means 4% of the variance in counselors' sexual comfort is due to counselors' sexual attitude on communion (idealistic sexuality). These results indicate a small effect size.

No correlation was found ($r = -.10, ns$) between the participants' sexual comfort scores and the participants' instrumentality scores. According to the analysis of this study, sexual comfort is weakly related to sexual attitudes towards instrumentality (biological, utilitarian sexuality). There is not a significant relationship between these variables.

Participants' training experience in sexual issues was measured by the *Sexuality Education Scale* (Harris & Hays, 2008), which consisted of item 30 in the survey. A Pearson product moment correlation was calculated using the participants' sexual comfort scores and training experience in sexual issues scores. The results of this correlation are presented in Table 12.

Table 12

Correlation Results of Participants' Scores of Sexual Comfort and Sexuality Education

		Sexual Comfort Scores
Sexuality Education Scores	Pearson Correlation	-.30*
	Sig. (2-tailed)	.00

n=221
 *Correlation is significant at the 0.01 level
 The lower the Sexual Comfort Score, the greater the sexual comfort.
 A higher the Sexuality Education score signifies a higher level of sexuality education.

A negative correlation was found ($r = -.30, p < .01$) between the participants' Sexual Comfort scores and their Sexuality Education scores. The relationship was significant at the .01 level. A relationship indicates that as sexual comfort scores decrease (and sexual comfort increases) sexuality education scores increase. Therefore, sexual comfort is significantly related to sexuality education, meaning the more human sexuality training and education a participant received, the greater his or her sexual comfort. In this relationship, an $r = -.30$, the $r^2 = .09$, which means 9% of the variance in counselors' sexual comfort is due to counselors' sexuality education. These results indicate a small effect size.

Items 33-56 contained *The Miller-Fisk 24-Item Sexual Knowledge Questionnaire* (SKQ; Gough, 1974), which measured participants' sexual knowledge. A Pearson product moment correlation was calculated using the participants' sexual comfort scores and sexual knowledge scores. The results of this correlation are presented in Table 13.

Table 13

Correlation Results of Participants' Scores of Sexual Comfort and Sexual Knowledge

		Sexual Comfort Scores
Sexual Knowledge Scores	Pearson Correlation	-.03
	Sig. (2-tailed)	.65

n=230
 The lower the Sexual Comfort Score, the greater the sexual comfort.
 A higher the Sexual Knowledge score signifies a higher level of sexuality knowledge.

No relationship was found ($r = -.03, ns$) between the participants' sexual comfort scores and the participants' sexual knowledge scores. According to the analysis of this study, sexual comfort is not related to sexual knowledge.

Participants' supervision experience addressing sexuality was measured by item 31 using the *Experience in Supervision Scale* (Harris & Hays, 2008). A Pearson product moment correlation was calculated using the participants' sexual comfort scores and supervision experience addressing sexuality scores. The results of this correlation are presented in Table 14.

Table 14

Correlation Results of Participants' Scores of Sexual Comfort and Experience in Supervision

		Sexual Comfort Scores
Experience in Supervision Scores	Pearson Correlation	-.19*
	Sig. (2-tailed)	.00

n=220
 *Correlation is significant at the 0.01 level
 The lower the Sexual Comfort Score, the greater the sexual comfort.
 The higher the Experience in Supervision score, the more experiences the respondent had discussing sexuality issues in the supervisory relationship.

A negative correlation was found ($r = -.19, p < .01$) between the participants' Sexual Comfort scores and their Experience in Supervision scores. The relationship was significant at the .01 level. A relationship indicates that as sexual comfort scores decrease (and sexual comfort increases) experience in supervision scores increase. Therefore, sexual comfort is significantly

related to supervision experience addressing sexuality. In this relationship, an $r = -.19$, the $r^2 = .03$, which means 3% of the variance in counselors' sexual comfort is due to counselors' supervision experience addressing sexuality. These results indicate a weak correlation and a small effect size. These results are statistically significant.

Participants' clinical experience with sexual issues were measured by the *Clinical Experience Scale* (CES; Harris & Hays, 2008), in item 32. A Pearson product moment correlation was calculated using the participants' sexual comfort scores and clinical experience with sexual issues scores. The results of this correlation are presented in Table 15.

Table 15
Correlation Results of Participants' Scores of Sexual Comfort and Clinical Experience

		Sexual Comfort Scores
Clinical Experience Scores	Pearson Correlation	-.12
	Sig. (2-tailed)	.07

n=221
The lower the Sexual Comfort Score, the greater the sexual comfort.
The higher the Clinical Experience score, the more clinical experience with clients with sexual issues.

No relationship was found ($r = -.12$, ns) between the participants' sexual comfort scores and the participants' clinical experience scores. According to the analysis of this study, sexual comfort is not related to clinical experience.

Research Question 3.

Research Question 3 asked if there was a relationship between the extent to which counselors discuss sexual issues with couples they counsel and their sexual attitudes, training experience in sexual issues, sexual knowledge, supervision experience addressing sexuality, and clinical experience with sexual issues. The extent to which counselors discuss sex with couples was

measured by the modified *Sexuality Discussions with Clients Scale* (SDCS, Harris & Hays, 2008), which consisted of items 28-29 in the survey. Counselors' sexual attitudes were measured by the *Brief Sexual Attitudes Scale* (BSAS; Hendrick, Hendrick, & Reich, 2006), which was made up of items 57-79. The *Brief Sexual Attitudes Scale* (BSAS; Hendrick, Hendrick, & Reich, 2006) consisted of four subscales: Permissiveness (which was measured by items 57-66), Birth Control (measured by items 67-69), Communion (measured by items 70-74), and Instrumentality (measured by items 75-79). Pearson product moment correlations were calculated using the participants' willingness to discuss sexual issues with couples they counsel scores and sexual attitude scores. The results of these correlations are presented in Table 16.

Table 16
Correlation Results of Participants' Scores of Sexuality Discussion with Couples and Sexual Attitude

		Sexuality Discussion with Couples Scores	
<hr/>			
Sexual Attitude			
Permissiveness	Pearson Correlation		-.01
	Sig. (2-tailed)		.87
Birth Control	Pearson Correlation		-.17*
	Sig. (2-tailed)		.01
Communion	Pearson Correlation		-.12
	Sig. (2-tailed)		.10
Instrumentality	Pearson Correlation		-.04
	Sig. (2-tailed)		.59

n=191 (Permissiveness)

n=203 (Birth Control)

n=200 (Communion)

n=201 (Instrumentality)

*Correlation is significant at the 0.05 level

The higher the Sexuality Discussion with Couples Score, the more willing therapists are to initiate sexuality discussions with couples.

The lower the Sexual Attitude Subscale Score, the greater that particular sexual attitude.

No correlation was found ($r = -.01$, *ns*) between the participants' sexuality discussion with couples scores and the participants' permissiveness scores. According to the analysis of

this study, sexuality discussion with couples is weakly related to sexual attitudes towards permissiveness (casual sexuality). There is not a significant relationship between these variables.

No correlation was found ($r = -.17, ns$) between the participants' sexuality discussion with couples scores and the participants' birth control scores. According to the analysis of this study, sexuality discussion with couples is weakly related to birth control. There is not a significant relationship between these variables.

No relationship was found ($r = -.12, ns$) between the participants' sexuality discussion with couples scores and the participants' communion scores. According to the analysis of this study, sexuality discussion with couples is weakly related to communion (idealistic sexuality). There is not a significant relationship between these variables.

No correlation was found ($r = -.04, ns$) between the participants' sexuality discussion with couples scores and the participants' instrumentality scores. According to the analysis of this study, sexuality discussion with couples is not related to instrumentality (biological, utilitarian sexuality). There is not a significant relationship between these variables.

No correlations were found between participants' sexuality discussion with couple's scores and any of the four subscales measuring sexual attitudes.

Participants' training experience in sexual issues was measured by the *Sexuality Education Scale* (Harris & Hays, 2008), which consisted of item 30 in the survey. A Pearson-product moment correlation was calculated using the participants' willingness to discuss sexual issues with couples they counsel scores and training experience in sexual issues scores. The results of this correlation are presented in Table 17.

Table 17

Correlation Results of Participants' Scores of Sexuality Discussion with Couples and Sexuality Education

	Sexuality Discussion with Couples Scores	
Sexuality Education Scores	Pearson Correlation	.26*
	Sig. (2-tailed)	.00

n=228

*Correlation is significant at the 0.01 level

The higher the Sexuality Discussion with Couples Score, the more willing therapists are to initiate sexuality discussions with couples.

A higher Sexuality Education score signifies a higher level of sexuality education and training.

A positive correlation was found ($r = .26, p < .01$) between the participants' sexuality discussion with couples scores and their sexuality education scores. The relationship was significant at the .01 level. A relationship indicates that as sexuality discussion with couples scores increase, sexuality education scores increase. Therefore, sexuality discussion with couples is significantly related to sexuality education. In this relationship, an $r = .26$, the $r^2 = .07$, which means 7% of the variance in the extent to which counselors discuss sexuality with couples is due to counselors' sexuality education. This indicates a low correlation and a small effect size. These results are statistically significant.

Items 33-56 contained *The Miller-Fisk 24-Item Sexual Knowledge Questionnaire* (SKQ; Gough, 1974), which measured participants' sexual knowledge. A Pearson product moment correlation was calculated using the participants' willingness to discuss sexual issues with couples they counsel scores and sexual knowledge scores. The results of this correlation are presented in Table 18.

Table 18

Correlation Results of Participants' Scores of Sexuality Discussion with Couples and Sexual Knowledge

	Sexuality Discussion with Couples Scores	
Sexual Knowledge Scores	Pearson Correlation	-.10
	Sig. (2-tailed)	.14

n=231
 The higher the Sexuality Discussion with Couples Score, the more willing therapists are to initiate sexuality discussions with couples.
 A higher Sexual Knowledge score signifies a higher level of sexuality knowledge.

No correlation was found ($r = -.10, ns$) between the participants' sexuality discussion with couples scores and the participants' sexual knowledge scores. According to the analysis of this study, sexuality discussion with couples is not related to sexual knowledge. There is not a significant relationship between these variables.

Participants' supervision experience addressing sexuality was measured by item 31 using the *Experience in Supervision Scale* (Harris & Hays, 2008). A Pearson product moment correlation was calculated using the participants' willingness to discuss sexual issues with couples they counsel scores and supervision experience addressing sexuality scores. The results of this correlation are presented in Table 19.

Table 19

Correlation Results of Participants' Scores of Sexuality Discussion with Couples and Experience in Supervision

	Sexuality Discussion with Couples Scores	
Experience in Supervision Scores	Pearson Correlation	.38*
	Sig. (2-tailed)	.00

n=228
 *Correlation is significant at the 0.01 level
 The higher the Sexuality Discussion with Couples Score, the more willing therapists are to initiate sexuality discussions with couples.
 The higher the Experience in Supervision score, the more experiences the respondent had discussing sexuality issues in the supervisory relationship.

A correlation was found ($r = .38, p < .01$) between the participants' sexuality discussion with couples scores and their experience in supervision scores. The relationship was significant at the .01 level. A relationship indicates that as sexuality discussion with couples scores increase, experience in supervision scores increase. Therefore, sexuality discussion with couples is significantly related to supervision experience addressing sexuality. In this relationship, an $r = .38$, the $r^2 = .14$, which means 14% of the variance in the extent to which counselors discuss sexuality with couples is due to counselors supervision experience addressing sexuality. This indicates a moderate correlation and a small effect size. These results are statistically significant.

Participants' clinical experience with sexual issues was measured by the *Clinical Experience Scale* (CES; Harris & Hays, 2008) in item 32. A Pearson product moment correlation was calculated using the participants' willingness to discuss sexual issues with couples they counsel scores and clinical experience with sexual issues scores. The results of this correlation are presented in Table 20.

Table 20
Correlation Results of Participants' Scores of Sexuality Discussion with Couples and Clinical Experience

	Sexuality Discussion with Couples Scores	
Clinical Experience Scores	Pearson Correlation	.16*
	Sig. (2-tailed)	.01

n=229
 *Correlation is significant at the 0.05 level
 The higher the Sexuality Discussion with Couples Score, the more willing therapists are to initiate sexuality discussions with couples.
 The higher the Clinical Experience score, the more clinical experience with clients with sexual issues.

No correlation was found ($r = .16, ns$) between the participants' sexuality discussion with couples scores and the participants' clinical experience scores. According to the analysis of this

study, sexuality discussion with couples is not related to clinical experience. There is not a significant relationship between these variables.

Research Question 4.

Research Question 4 asked which influencing variables (sexual attitudes, training experience in sexual issues, sexual knowledge, supervision experience addressing sexuality, and clinical experience with sexual issues) predicted a counselor's comfort level with sexuality. A stepwise linear regression was conducted to determine whether one or more of the variables (sexual attitudes, training experience in sexual issues, sexual knowledge, and supervision experience addressing sexuality) can adequately predict counselor sexual comfort level. The analysis revealed that counselors' sexual comfort can be predicted by the following variables: (1) training experience in sexual issues/sexual education; (2) sexual attitudes on communion; (3) sexual attitudes on instrumentality; and (4) sexual attitudes on permissiveness. A significant regression equation was found ($F=10.33$, $p<.01$, $n=181$), with an *R square* of .190. More than 9% of the variance in sexual comfort scores was explained by training experience in sexuality or sex education. Training experience in sexuality or sex education and sexual attitudes regarding communion could account for 13% of the variance in sexual comfort. Training experience in sexuality or sex education, sexual attitudes regarding communion, and sexual attitudes regarding instrumentality could account for 15% of the variance in sexual comfort. Training experience in sexuality or sex education, sexual attitudes regarding communion, sexual attitudes regarding instrumentality, and sexual attitudes regarding permissiveness could account for 19% of the variance in sexual comfort. The following variables were found not to be predictors of sexual comfort: sexual attitudes regarding birth control, sexual knowledge, supervision experience addressing sexuality, and clinical experience with sexual issues. See results in Table 21.

Table 21

Stepwise Linear Regression Analysis Predicting Participants' Sexual Comfort

Variable	R^2	Sexual Comfort	β
Step 1			
Sexual Education/Training	.091*		-.302
Step 2			
Communion-Sexual Attitude	.129*		.194
Step 3			
Instrumentality-Sexual Attitude	.149*		-.142
Step 4			
Permissiveness-Sexual Attitude	.190*		.234

n=181
*p<.01

Research Question 5.

Research Question 5 asked which influencing variables (sexual attitudes, training experience in sexual issues, sexual knowledge, supervision experience addressing sexuality, and clinical experience with sexual issues) predicted the extent to which counselors will discuss sexual issues with couples they counsel. A stepwise linear regression was conducted to conclude whether one or more of the variables (sexual attitudes, training experience in sexual issues, sexual knowledge, supervision experience addressing sexuality, and clinical experience with sexual issues) can adequately predict the extent to which counselors discuss sexual issues with couples they counsel. The analysis revealed that the extent to which counselors discuss sexual issues with couples can be predicted by the following variables: (1) supervision experience addressing sexuality; and (2) sexual attitudes regarding birth control. A significant regression equation was found ($F=18.20$, $p<0.01$, $n=190$), with an *R square* of .163. Over 14% of variance in the extent to which counselors discuss sexual issues with couples was explained by supervision experience addressing sexuality, and 16% of variance in the extent to which

counselors discuss sexual issues with couples was explained by supervision experience addressing sexuality and sexual attitudes regarding birth control. The following variables were found not to be predictors of sexual comfort: sexual attitudes on Communion, sexual attitudes on instrumentality, sexual attitudes on permissiveness, training experience in sexual issues, sexual knowledge, and clinical experience with sexual issues. See results in Table 22.

Table 22
Stepwise Linear Regression Analysis Predicting Participants' Sexual Discussion with Couples

Variable	Sexual Discussion with Couples	
	R^2	β
Step 1		
Experience in Supervision	.144*	.380
Step 2		
Birth Control-Sexual Attitude	.163*	-.137

n=190
 *p<.01

Research Question 6.

Research Question 6 asked if there was a relationship between the sexual comfort of counselors and counselors' sex, age, strength of faith, sexual orientation, number of years practicing, practice setting, type of license, type of graduate specialization, or relationship status. Counselors' sexual comfort was measured by Part 1 of the *Sexual Comfort Instrument* (SCI; Hedgepeth, 1988), which consisted of items 10-27 of the survey. Item 1 measured the sex of the participants. A chi square measure of association was calculated using the participants' sexual comfort scores and their sexes. The results of this analysis were not significant, indicating that males and females did not differ in their levels of sexual comfort ($\chi^2=33.13$, $df=31$, $N=229$, $p>0.01$).

Participants' age was measured by item 2. A Pearson product moment correlation was calculated using the participants' sexual comfort scores and their ages. The results of this correlation are presented in Table 23.

Table 23
Correlation Results of Participants' Scores of Sexual Comfort and Age

		Sexual Comfort Scores
Age	Pearson Correlation	-.18*
	Sig. (2-tailed)	.00

n=226
 *Correlation is significant at the 0.01 level
 The lower the Sexual Comfort Score, the greater the sexual comfort.

A negative correlation was found ($r = -.18, p < .01$) between the participants' sexual comfort scores and their ages. The relationship was significant at the .01 level. A relationship indicates that as age increases, sexual comfort scores decrease (and sexual comfort increases). Therefore, counselors' sexual comfort is significantly related to age. In this relationship, an $r = -.18$, the $r^2 = .03$, which means 3% of the variance in counselors' sexual comfort is due to counselors' age. This indicates a small effect size. These results are statistically significant.

Item 3 measured participants' strength of faith using a 5-point Likert-type scale ranging from weak to strong. A Pearson product moment correlation was calculated using the participants' sexual comfort scores and their strength of faith. The results of this correlation are presented in Table 24.

Table 24

Correlation Results of Participants' Scores of Sexual Comfort and Strength of Faith

		Sexual Comfort Scores
Strength of Faith	Pearson Correlation	.14*
	Sig. (2-tailed)	.04

n=230
 *Correlation is significant at the 0.05 level
 The lower the Sexual Comfort Score, the greater the sexual comfort.

No correlation was found ($r = .14, ns$) between the participants' sexual comfort scores and the participants' strength of faith. According to the analysis of this study, sexual comfort is weakly related to strength of faith. There is not a significant relationship between these variables.

Participants' sexual orientation was measured by item 4. A chi square measure of association was calculated using the participants' sexual comfort scores and their sexual orientation. The results of this analysis were not significant, indicating that bisexuals, heterosexuals, homosexuals, and "other" did not differ in their levels of sexual comfort ($\chi^2=117.2, df=93, N=230, p>0.01$).

Item 5 measured participants' years of experience. A Pearson product moment correlation was calculated using the participants' sexual comfort scores and the number of years they have been practicing. The results of this correlation are presented in Table 25.

Table 25

Correlation Results of Participants' Scores of Sexual Comfort and Years of Practice

		Sexual Comfort Scores
Years of Practice	Pearson Correlation	-.20*
	Sig. (2-tailed)	.00

n=228
 *Correlation is significant at the 0.01 level
 The lower the Sexual Comfort Score, the greater the sexual comfort.

A correlation was found ($r = -.20, p < .01$) between the participants' sexual comfort scores and their years of practice. The relationship was significant at the .01 level. A relationship indicates that as sexual comfort scores decrease (and sexual comfort increases), years of practice increases. Therefore, counselors' sexual comfort is significantly related to years of practice. The more years of practice a counselor has, the greater his or her sexual comfort. In this relationship, an $r = -.20$, the $r^2 = .04$, which means 4% of the variance in counselors' sexual comfort is due to counselors' years of practice. This indicates a weak relationship and a small effect size. These results are statistically significant.

Participants' practice setting was measured by item 6. A chi square measure of association was calculated using the participants' sexual comfort scores and their practice settings. The results of this analysis were not significant, indicating that counselors' levels of sexual comfort did not differ depending on their practice settings ($\chi^2=111.4, df=124, n=228, p>0.01$).

Item 7 measured participants' type of license. A chi square measure of association was calculated using the participants' sexual comfort scores and their types of license (LPC, LMFT, or other). The results of this analysis were not significant, indicating that counselors' levels of sexual comfort did not differ depending on their types of license ($\chi^2=129.3, df=124, n=230, p>0.01$).

Participants' graduate specialization was measured by item 8. A chi square measure of association was calculated using the participants' sexual comfort scores and the types of graduate specialization they studied in their graduate work. The results of this comparative analysis were not significant, indicating that counselors' levels of sexual comfort did not differ depending on their graduate specializations ($\chi^2=148.8, df=150, n=204, p>0.01$).

Item 9 measured participants' relationship statuses. A chi square measure of association was calculated using the participants' sexual comfort scores and their relationship statuses. The

results of this comparative analysis were not significant, indicating that counselors' levels of sexual comfort did not differ depending on their relationship statuses ($\chi^2=162.3$, $df=124$, $n=230$, $p>0.01$).

Research Question 7.

Research Question 7 asked if there was a relationship between the extent to which counselors discuss sexual issues with couples they counsel and counselors' sex, age, strength of faith, sexual orientation, number of years practicing, practice setting, type of license, type of graduate program, or relationship status.

A chi square measure of association was calculated using the participants' extents to which they discuss sexual issues with couples they counsel scores and their sex. The results of this analysis were not significant, indicating that the extent to which counselors discuss sexual issues with couples did not differ depending on whether the counselors were male or female ($\chi^2=57.47$, $df=50$, $n=230$, $p>0.01$).

A Pearson product moment correlation was calculated using the participants' extent to which they discuss sexual issues with couples they counsel scores and their ages. The results of this correlation are presented in Table 26.

Table 26
Correlation Results of Participants' Scores of Sexuality Discussion with Couples and Age

	Sexuality Discussion with Couples Scores	
Age	Pearson Correlation	.18*
	Sig. (2-tailed)	.01

n=228

*Correlation is significant at the 0.01 level

The higher the Sexuality Discussion with Couples Score, the more willing therapists are to initiate sexuality discussions with couples.

A positive correlation was found ($r = .18, p < .01$) between the participants' sexuality discussion with couples scores and their ages. The relationship was significant at the .01 level. This indicates that as counselors' ages increase, their sexuality discussion with couples scores increase. Therefore, counselors' sexuality discussion with couples is significantly related to age, in that the older counselors tend to be more likely to discuss sexual issues with couples they counsel. In this relationship an $r = .18$, the $r^2 = .03$, which means 3% of the variance in the extent to which counselors discuss sexual issues with couples is due to counselors' ages. These results are statistically significant and the effect size is small.

A Pearson product moment correlation was calculated using the participants' extent to which they discuss sexual issues with couples they counsel scores and their strength of faith. The results of this correlation are presented in Table 27.

Table 27
Correlation Results of Participants' Scores of Sexuality Discussion with Couples and Strength of Faith

		Sexuality Discussion with Couples Scores
Strength of Faith	Pearson Correlation	.04
	Sig. (2-tailed)	.55

N=231
The higher the Sexuality Discussion with Couples Score, the more willing therapists are to initiate sexuality discussions with couples.

No relationship was found ($r = .04, ns$) between the participants' sexuality discussion with couples scores and the participants strength of faith. According to the analysis of this study, sexuality discussion with couples is not related to strength of faith. There is not a significant relationship between these variables.

A chi square measure of association was calculated using the participants' extent to which they discuss sexual issues with couples they counsel scores and their sexual orientations. The results of this analysis were not significant, indicating that the extent to which counselors discuss sexual issues with couples did not differ depending on their sexual orientations ($\chi^2=158.9$, $df=150$, $n=231$, $p>0.01$).

A Pearson product moment correlation was calculated using the participants' extent to which they discuss sexual issues with couples they counsel scores and the number of years they have been practicing. The results of this correlation are presented in Table 28.

Table 28
Correlation Results of Participants' Scores of Sexuality Discussion with Couples and Years of Practice

		Sexuality Discussion with Couples Scores
Years of Practice	Pearson Correlation	.11
	Sig. (2-tailed)	.11

N=229
The higher the Sexuality Discussion with Couples Score, the more willing therapists are to initiate sexuality discussions with couples.

No relationship was found ($r = .11$, ns) between the participants' sexuality discussion with couples scores and the participants' years of practice. According to the analysis of this study, counselors' sexuality discussion with couples is not related to their years of practice. There is not a significant relationship between these variables.

A chi square measure of association was calculated using the participants' extent to which they discuss sexual issues with couples they counsel scores and their practice settings. The results of this analysis were not significant, indicating that the extent to which counselors

discuss sexual issues with couples did not differ depending on their practice settings ($\chi^2=222.7$, $df=200$, $n=229$, $p>0.01$).

A chi square measure of association was calculated using the participants' extent to which they discuss sexual issues with couples they counsel scores and their types of license (LPC, LMFT, or other). The results of this analysis were not significant, indicating that the extent to which counselors discuss sexual issues with couples did not differ depending on their types of license ($\chi^2=244.3$, $df=200$, $n=231$, $p>0.01$).

A chi square measure of association was calculated using the participants' extent to which they discuss sexual issues with couples they counsel scores and the type of graduate specializations they studied in their graduate work. The results of this analysis were significant, indicating that the extent to which counselors discuss sexual issues with couples did differ depending on their graduate specializations ($\chi^2=318.7$, $df=250$, $n=202$, $p>0.01$).

A chi square measure of association was calculated using the participants' extent to which they discuss sexual issues with couples they counsel scores and their relationship statuses. The results of this analysis were not significant, indicating that the extent to which counselors discuss sexual issues with couples did not differ depending on relationship statuses ($\chi^2=234.1$, $df=200$, $n=231$, $p>0.01$).

Qualitative Analysis

At the end of the survey participants were given the option to respond to the following open-ended statement: "Please share any additional information you feel is relevant to the topic of counselors' comfort level and willingness to discuss sexual issues with couples in the space provided." Of the 304 participants surveyed, 15 chose to respond. Almost 5% of participants chose to respond to the statement, yielding a very low response rate.

Based on a review of the responses, I excluded those responses that were not pertinent to the study. Every response can be found in Appendix E. The following themes were found using constant comparison/grounded theory qualitative data analysis.

Discussing sexuality with couples may be awkward but it is important.

The following responses help to support this theme.

-“It is very awkward, but one ought to learn to tolerate awkward conversations, I suppose.”

- “I feel counselors must discuss sex and sexuality with clients just as we discuss any other topic. I think we need to address counselor's discomfort talking about sex/sexuality and the lack of skill in treating sexual issues. It is terrible that most counselors do not feel comfortable in this area. It is just another aspect of human experience.”

- “Counselors should strive to be at ease when talking to clients about sexual issues.”

Personal versus professional.

Counselors’ practices may be influenced by their personal lives and their personal practices may be different from their professional practices. The following responses help to support this theme.

- “I find that my comfort level in a counseling setting is very different than the comfort level in my own life. I think I am completely comfortable talking to a couple or individual who is experiencing sexuality issues, although in my own life I am somewhat quiet about it even with my husband.”

- “I think having children, adult children, have educated me much more concerning sexuality. Two of my children are gay, so this experience of accepting them has taught me much about being tolerant and accepting of my client's sexual behaviors and problems.”

Importance of abuse history.

The following response helps to support this theme.

- “Counselor's previous personal sexual abuse history.”

Focus on clients' needs.

The counselors' role is to focus on the clients' needs and help them explore their sexuality when they feel ready. The following responses help support this theme.

- “I am more concerned with feelings than biology. I have seen extremes from no sex to many partners, what is right for one person may be totally wrong for another. It is important to help the client clarify their own values and beliefs in terms of sexuality not impose others ideas. Only rule - do no harm to self or others.”

- “As a counselor, I look to the client to dictate what he/she is comfortable talking about. I don't feel uncomfortable talking about any things sexual. My difficulty always lies in figuring out how to approach sexual topics with clients in a way that helps them say what they need to say. In my experience, these have often been very religious people who have difficulty.”

Counselors' beliefs, attitudes, and biases.

Counselors' attitudes and beliefs can influence their ability to work with client sexual issues. The following responses support this theme.

- “I am very comfortable counseling couples and individuals on sexual topics.”

- “Sex impacts the whole person. Heart (that which we cherish) & Spirit (our relationship with God), Soul (Mind, emotions & will), the Body (physically & chemically) and Relationally.”

- “Some of these questions assume heterosexuality. As an individual who does not consider themselves heterosexual, such questions regarding birth control methods and whether men or women should share responsibility for birth control, do not apply. These questions limit

the reliability of this survey. As a therapist, you must also consider how your choice of words and questions reflect your heteronormative bias.”

- “I am a strong proponent of anything goes between a married man and woman in the privacy of their bedroom as long as both are comfortable. I believe the sexual experience is a part of a healthy marriage. I believe sexual activity should be restricted to marriage. I work with sexual addicts, homosexuals, and marriages struggling with adultery. I do not condemn them, but help them strive for sexual purity within marriage.”

There are some interesting points made but with such a low response, little definitive qualitative information was obtained overall. Future studies may want to qualitatively explore counselors’ feelings and practices regarding sexuality.

Summary

In summary, the following results were found upon data analysis. A negative correlation was found ($r = -.40, p < .01$) between the participants’ sexual comfort scores and their sexual discussion with couples scores. This indicates that the greater a counselor’s sexual comfort, the more willing he or she is to discuss sexuality with couples he or she counsels. When correlation analysis was performed on participants’ sexual comfort and the other variables measured, the following results were revealed. A small correlation was found ($r = .19, p < .01$) between the participants’ sexual comfort scores and their communion scores. Therefore, sexual comfort was significantly related to sexual attitudes towards communion or idealistic sexuality. A negative correlation was found ($r = -.30, p < .01$) between the participants’ Sexual Comfort scores and their Sexuality Education scores. Therefore, sexual comfort was significantly related to sexuality education, meaning the more human sexuality training and education a participant received, the greater his or her sexual comfort. A negative correlation was found ($r = -.19, p < .01$) between

the participants' Sexual Comfort scores and their Experience in Supervision scores. As a result, sexual comfort was significantly related to supervision experience addressing sexuality.

Next, correlational analyses were calculated on participants' sexuality discussion with couples scores and the other variables measured. A positive correlation was found ($r = .26, p < .01$) between the participants' sexuality discussion with couples scores and their sexuality education scores. This reveals that sexuality discussion with couples was significantly related to sexuality education. A correlation was found ($r = .38, p < .01$) between the participants' sexuality discussion with couples scores and their experience in supervision scores. Sexuality discussion with couples was significantly related to supervision experience addressing sexuality.

A stepwise linear regression was conducted to determine whether one or more of the variables (sexual attitudes, training experience in sexual issues, sexual knowledge, and supervision experience addressing sexuality) can adequately predict counselor sexual comfort level. The analysis revealed that counselors' sexual comfort can be predicted by the following variables: (1) training experience in sexual issues/sexual education; (2) sexual attitudes on communion; (3) sexual attitudes on instrumentality; and (4) sexual attitudes on permissiveness. A significant regression equation was found ($F=10.33, p < .01, n=181$), with an *R square* of .190. A stepwise linear regression was conducted to conclude whether one or more of the variables (sexual attitudes, training experience in sexual issues, sexual knowledge, supervision experience addressing sexuality, and clinical experience with sexual issues) can adequately predict the extent to which counselors discuss sexual issues with couples they counsel. The analysis revealed that the extent to which counselors discuss sexual issues with couples can be predicted by the following variables: (1) supervision experience addressing sexuality; and (2) sexual

attitudes regarding birth control. A significant regression equation was found ($F=18.20, p<0.01, n=190$), with an R square of .163.

Correlational and chi square analysis were performed to determine the relationship between participants' sexual comfort and the demographic variables. A negative correlation was found ($r = -.18, p < .01$) between the participants' sexual comfort scores and their ages. A counselor's sexual comfort is significantly related to his or her age. A correlation was found ($r = -.20, p < .01$) between the participants' sexual comfort scores and their years of practice. A counselor's sexual comfort is significantly related to years of practice. The more years of practice a counselor has, the greater his or her sexual comfort. The chi square analysis found no relationships among variables with sexual comfort.

Correlational and chi square analyses were performed to determine the relationship between the extent to which participants discuss sexual issues with couples they counsel and the demographic variables. A positive correlation was found ($r = .18, p < .01$) between the participants' sexuality discussion with couples scores and their ages. Therefore, counselors' sexuality discussion with couples is significantly related to age, in that older counselors tend to be more likely to discuss sexual issues with couples they counsel. A chi square measure of association was calculated using the participants' extent to which they discuss sexual issues with couples they counsel scores and the type of graduate specializations they studied in their graduate work. The results of this associational analysis were significant, indicating that the extent to which counselors discuss sexual issues with couples did differ depending on their graduate specializations ($\chi^2=318.7, df=250, n=202, p>0.01$).

CHAPTER FIVE

Discussion

Purpose of the Study

The purpose of this study was to examine the factors that influence counselors' sexual comfort and willingness to discuss sexuality and sexual issues with couples they are counseling. Thus, I explored the relationship between the two dependent variables: counselors' sexual comfort and counselors' willingness to discuss sexual issues with couples they counsel. The independent variables were counselors': sexual attitudes, training and experience in discussing sexual issues, sexual knowledge, supervision experience addressing sexuality, and clinical experience discussing sexual issues. I sought to determine whether or not these variables had a relationship with counselors' sexual comfort and counselors' willingness to discuss sexual issues with couples they counsel. My expectation was that counselor educators would be able to utilize the findings to increase counselors' in training sexual comfort and willingness to discuss sexual issues with the couples they counsel.

Discussion of Findings

This study extended Harris and Hays's research by focusing specifically on whether or not counselors explore sexuality in couples counseling. My study focused on counselors instead of MFTs to examine whether or not Harris and Hay's findings can be generalized to include the all counselors. Survey design was used to measure counselors': willingness to discuss sexual issues with couples, sexual comfort, sexual attitudes, sexual knowledge, training experience with sexual issues, supervision experience addressing sexuality, and clinical experience with sexual issues. I chose to focus on counselors' work with couples because of the importance sex has in relationships (Byers, 2005; Donnelly, 1993; Guo & Huang, 2005; Hatfield et al., 1982; McCabe, 1999; Sprecher, 1998). Harris and Hays (2008) were two of the first researchers to empirically

study therapists' willingness to discuss sexual issues with clients by surveying MFTs regarding their: willingness to discuss sexual issues with clients, sexual comfort, sexual knowledge, sexuality education and training, clinical experience with sexual issues, and supervision experience in addressing sexuality. Harris and Hays's research is a precursor to my study.

Other researchers have tested some of the variables that I explored, such as counselors' sexual comfort, sexual attitudes, and sexual knowledge (e.g., Anderson, 2002; Arnold, 1980; Ford & Hendrick, 2003; Haboubi & Lincoln, 2003; McConnell, 1976; Meisel, 1977). The results of those studies are often conflicting, which is why I included counselors' sexual comfort, sexual attitudes, and sexual knowledge as variables in my study. Arnold's study found no relationship between counseling students' comfort level working with clients with sexual issues and sexual knowledge, level of education, and personal sexual experience. These results conflict with Harris and Hays's (2008) finding that as counselors' sexual knowledge increases, so does their level of sexual comfort. Anderson did not find a relationship between sexual knowledge and sexual comfort, although she maintains that knowledge about sex is an important factor in increasing counselors' willingness to discuss sexual issues with clients (Anderson, 2002). Therefore, it is important to examine the education and training opportunities regarding sex and sexuality that are available in counselor education programs. My study helped to clarify the conflicting results and illuminated the fact that counselors receive limited education and training in their graduate course work.

Harris and Hays were the first researchers to examine the role supervision experience plays in counselors' willingness to discuss sexuality with clients. In order to further investigate Harris and Hays's findings, I measured counselors' supervision experience in my study. My findings added to the limited body of literature on the factors that influence counselors' sexual

comfort and their willingness to discuss sexual issues with clients and couples. I will explain the results of my research and the implications of the findings as they relate to counselors, counselor educators, and supervisors.

Sexual comfort.

Sexual comfort and sexual discussion with couples.

Correlational, comparative, and regression analyses were performed to examine the relationship between sexual comfort and the other measured variables. A statistically significant correlation was found between counselors' sexual comfort and the extent to which counselors discuss sexual issues with couples ($r = -.40, p < .01$). This result indicates a moderate relationship with an R square of .16, indicating that 16% of the variance in sexual comfort scores was explained by counselors' willingness to discuss sexual issues with couples. This finding suggests that the more comfortable counselors are with sexuality, the more likely they are to discuss sexuality with couples they counsel. It seems logical that a counselor would need to be comfortable with a topic in order to explore it with clients. This finding is similar to Guldner and Guldner's (1992) belief that counselors who have discomfort with sex and sexuality in general tend to avoid the topic. In addition, Roche (1998) found a positive relationship between high school counselors' sexual comfort and their willingness to discuss sexual issues with adolescent clients. As high school counselors' sexual comfort increased, so did their willingness to discuss sexual issues with adolescents. The findings of my study and other studies seem to indicate that counselors' comfort level and their willingness to discuss sexual issues are correlated regardless of the population with whom a counselor is working. In a more recent study, Harris and Hays (2008) examined factors that influence marriage and family therapists' (MFT) willingness to initiate sexual discussions with their clients. The second greatest predictor

in determining whether or not MFTs would initiate sexual discussion with clients was sexual comfort level. Therefore, the findings of my study, which examined counselors instead of MFTs, are consistent with the theories and findings of previous research.

Sexual comfort and sexual attitudes.

When sexual comfort was compared to sexual attitudes regarding communion (idealistic sexuality) a significant correlation was found ($r = .19, p < .01$). This indicates small yet meaningful effects. These findings imply that the more communion or idealistic attitude counselors have about sex, the greater their sexual comfort. Thus, counselors who view sexuality as a very important bonding activity between partners in a relationship tend to be more comfortable with sexuality. This finding supports Anderson's (2002) research results, which showed that counselors who had more liberal sexual attitudes and values had higher levels of sexual comfort. Of all the variables measured by Anderson, a counselor's sexual attitude was the greatest predictor of high levels of sexual comfort (Anderson, 2002). The findings in my study are consistent with Anderson's in regards to sexual attitudes about communion in that they show that a relationship exists between these variables. However, my findings conflicted with Anderson's when sexual comfort was compared to counselors' sexual attitudes and beliefs regarding permissiveness, birth control, and instrumentality.

Sexual comfort and sexuality education and training.

A statistically significant correlation was found between counselors' sexual comfort and their human sexuality education and training ($r = -.30, p < .01$). This indicates a small to moderate effect size. A negative correlation was found as a result of reverse coding, although a positive relationship exists. However, the relationship indicates that the more training and human sexuality education a counselor receives, the more comfortable he or she is with sexuality. This

relationship seems logical because the more one knows about a topic, the more likely one is to be comfortable with that topic. Similar findings were reported by Roche (1998), who found a positive relationship between high school counselors' sexual comfort and their levels of human sexuality education. Of the high school counselors surveyed, those with higher levels of human sexuality education had higher levels of sexual comfort than those with less human sexuality education (Roche, 1998). Anderson (2002) found in her study that the more sexuality training counselors had received, the more comfortable they were with sexuality and sexual issues. The results of my study help to confirm the findings from these two previous studies.

Sexual comfort and supervision experience with sexuality.

When a correlational analysis was conducted between counselors' sexual comfort and their supervision experience in addressing sexual issues, a significant relationship was found ($r = -.19, p < .01$). A negative correlation was found due to reverse coding, although a positive relationship exists. This indicates a small to medium effect size. This indicates that the more supervision experience a counselor has had in addressing sexuality, the more comfortable he or she is with sexuality. These results are similar to the findings of Harris and Hays (2008). They found that more supervision experience in addressing sexual issues led to increased sexual comfort levels in MFTs, although my participants were counselors instead of MFTs. According to Giami and Pacey (2006), supervision is a very important aspect of counselors' clinical training. It makes sense that what is covered in supervision would be related to counselor comfort levels. I assume that exploring topics in supervision helps counselors and counselors in training to be more comfortable with the topics. My study provides evidence that supports this assumption.

Sexual comfort and age.

A correlational analysis revealed a statistically significant relationship between counselors' sexual comfort and their age ($r = -.18, p < .01$). A negative correlation was found due to reverse coding, although the variables are positively related. These results indicate that the older a counselor is, the more comfortable he or she is with sexuality. This relationship is a new finding. I assume that the older a counselor is, the longer he or she has been practicing and the more experience he or she has. In addition, one could speculate that older counselors lived through the sexual revolution and, as a result, may be more comfortable with sexuality. These are some possible explanations for this finding.

Sexual comfort and years of practice.

A statistically significant correlation ($r = -.20, p < .01$) was found between counselors' sexual comfort and their years of practice. This is a small effect size. Therefore, the longer a counselor has been practicing in the field, the greater his or her sexual comfort. This is consistent with the finding that the older a counselor may be, the greater his or her sexual comfort, because counselors who have been practicing longer are more likely to be older. Anderson (2002) also found in her study that the number of years counselors practiced positively correlated with their sexual comfort. In other words, counselors who had been practicing longer had higher levels of sexual comfort; these findings are supported by my research. It is reasonable to assume that if age is related to sexual comfort, years of practice would be, as well. However, clinical experience with sexual issues was not related to counselors' sexual comfort in this study. This may indicate that the more general experience a counselor has, the more comfortable he or she is with sexuality, but specific experience working with sexual issues may

result in discomfort. This may be due to negative experience working with sexual issues, leading to discomfort.

Other variables.

After correlational and analyses were conducted, the following variables did not have statistically significant relationships with counselors' sexual comfort: sexual attitudes towards permissiveness, sexual attitudes towards birth control, sexual attitudes towards instrumentality, sexual knowledge, clinical experience with sexual issues, sex, sexual orientation, strength of faith, practice setting, type of license, graduate specialization, and relationship status. These findings imply that regardless of counselors' sexual attitudes towards permissiveness, sexual attitudes towards birth control, sexual attitudes towards instrumentality, sexual knowledge, clinical experience with sexual issues, sex, sexual orientation, strength of faith, practice setting, type of license, graduate specialization, and relationship status, sexual comfort is related to the following variables: willingness to discuss sexual issues with couples, sexual attitudes regarding communion (idealistic sexuality), human sexuality education and training, experience in supervision addressing sexuality, age, and years of practice.

The fact that these variables did not have statistically significant relationships with sexual comfort is important. Although Anderson (2002) found that counselors who had more liberal sexual attitudes and values had higher levels of sexual comfort, my study found only a relationship between sexual comfort and sexual attitudes regarding communion (idealistic sexuality). Counselors' sexual attitudes regarding permissiveness, birth control, and instrumentality did not have a relationship with sexual comfort. However, counselors' sexual attitudes regarding permissiveness, communion, and instrumentality were found to be predictive variables of sexual comfort. This means that counselors' sexual comfort did not change

depending on their sexual attitudes regarding permissiveness, birth control, and instrumentality. However, if provided with information on a counselor's sexual attitude regarding either permissiveness, communion, or instrumentality, one could predict his or her sexual comfort level. This finding is consistent with Arnold's (1980) and Anderson's (2002) findings.

These results conflict with Harris and Hays's (2008) finding that as counselors' sexual knowledge increases, so does level of sexual comfort. Although no correlation was found between counselors' sexual comfort and their sexual knowledge ($r = -.03$, *ns*), a relationship was found between sexual comfort and training experience. Sexual knowledge is an aspect of sexuality education that should not be ignored; however, increasing counselors' sexual knowledge should not be the main focus of counseling programs that are increasing levels of training (Harris & Hays, 2008).

Clinical experience was also not related to counselors' sexual comfort, and neither were a variety of demographic variables, such as: sex, sexual orientation, strength of faith, practice setting, type of license, graduate specialization, and relationship status. This means that sexual comfort did not change depending on counselors': clinical experience with sexual issues, sex, sexual orientation, strength of faith, practice setting, type of license, graduate specialization, or relationship status. It is important to note that if counselors are not provided proper training in human sexuality issues, they will not become more comfortable with sexuality simply by gaining experience working with sexual issues. The lack of a relationship may be because counselors have had negative clinical experiences working with sexual issues that resulted in discomfort with sexuality.

Sexual comfort and predictive variables.

A stepwise regression analysis revealed that the single greatest predictor of counselors' sexual comfort was education and training experience in human sexuality ($R\ Square=.091$). The second greatest predictor of counselors' sexual comfort, in conjunction with sexual education and training, was counselors' sexual attitudes regarding communion or idealistic sexuality ($R\ Square=.129$). The R increases in each step of the regression. This is due to the fact that once other variables are added, the prediction increases. The third greatest predictor of counselors' sexual comfort, in conjunction with sexual education and training and counselors' sexual attitudes regarding communion or idealistic sexuality, was counselors' sexual attitudes on instrumentality or biological and utilitarian sexuality ($R\ Square=.149$). The fourth and final greatest predictor of counselors' sexual comfort, in conjunction with sexual education and training, counselors' sexual attitudes regarding communion or idealistic sexuality, and counselors' sexual attitudes on instrumentality or biological and utilitarian sexuality, was counselors' sexual attitudes regarding permissiveness ($R\ Square=.190$). Communion, instrumentality, and permissiveness were three of the four subscales on the *Brief Sexual Attitudes Scale*. An inference can be made that, after counselors' human sexuality education and training experience, a combination of counselors' human sexuality education and training experience and their sexual attitudes were the greatest predictors of higher levels of sexual comfort. These results are similar to Anderson's (2002) findings, that of all the variables measured in her study, a counselor's sexual attitude was the greatest predictor of high levels of sexual comfort. The combination of variables that best predicted increased levels of sexual comfort in counselors were sexual attitudes, training experience in sexuality and sexual issues, and personal sexual experience.

The following variables were not found to be predictors of counselors' sexual comfort: sexual attitudes regarding birth control, sexual knowledge, supervision experience addressing sexuality, and clinical experience with sexual issues. This means that having information on a counselor's sexual attitudes regarding birth control, sexual knowledge, supervision experience addressing sexuality, or clinical experience with sexual issues would not help to predict his or her sexual comfort. These results conflict with Anderson's (2002) finding that a counselor's sexual attitude was the greatest predictor of a high level of sexual comfort. The results regarding clinical experience are consistent with Harris and Hay's (2008) finding that no relationship exists between counselors' sexual comfort and their clinical experience with sexual issues.

Table 29 shows which variables were related to sexual comfort.

Table 29
Correlation Results of Participants' Scores of Sexual Comfort

	Sexual Comfort Scores	
Sexuality Discussion with Couples Scores	Pearson Correlation	-.40*
	Sig. (2-tailed)	.00
Communion	Pearson Correlation	.19*
	Sig. (2-tailed)	.00
Sexuality Education Scores	Pearson Correlation	-.30*
	Sig. (2-tailed)	.00
Experience in Supervision Scores	Pearson Correlation	-.19*
	Sig. (2-tailed)	.00
Age	Pearson Correlation	-.18*
	Sig. (2-tailed)	.00
Years of Practice	Pearson Correlation	-.20*
	Sig. (2-tailed)	.00

Sexual discussion with couples.

Sexual discussion with couples and sexuality training and education.

The next dependent variable measured was the extent to which counselors discuss sexual issues with couples. Correlation and regression analyses were performed to examine the

relationship between a counselor's willingness to discuss sexual issues with couples and other variables. Based on the results of a correlational analysis, a statistically significant relationship was found between counselors' willingness to discuss sexual issues with couples and their human sexuality training and education ($r = .26, p < .01$). Inference can be made from these results that the more training and education experience a counselor has with human sexuality, the more likely he or she is to discuss sexual issues with couples. Therefore, if counselors receive more human sexuality education and training, they may be more likely to discuss sexual issues with couples. This finding has major implications for counselors and counselor educators, which I will discuss in more detail later. This finding supports Guldner and Guldner's (1992) theory that counselors who have not been formally trained in dealing with clients' sexual issues and who have discomfort with sex and sexuality in general tend to avoid the topic (Guldner & Guldner, 1992). This finding is similar to Harris and Hay's (2008) finding that the strongest predictors for whether or not marriage and family therapists would initiate sexual discussions with their clients were sexuality education and supervision experience with sexual issues. This finding is consistent with previous research.

Sexual discussion with couples and supervision experience with sexuality.

A statistically significant correlation was found between counselors' willingness to discuss sexual issues with couples and their supervision experience addressing sexuality ($r = .38, p < .01$). This indicates a moderate effect size and that the more supervision experience a counselor has had addressing sexuality, the more likely he or she is to discuss sexual issues with couples. This means that if supervisors model the discussion of sexuality and encourage their supervisees to explore their own and clients' sexuality, then the supervisees may be more likely to discuss sexual issues with couples. As previously stated, Harris and Hay (2008) had a similar

finding regarding supervision experience with sexuality and counselors' willingness to discuss sexual issues with clients. This finding is consistent with previous research and has implications for counselor educators and supervisors that I will discuss further.

Sexual discussion with couples and age.

A statistically significant relationship was found between counselors' willingness to discuss sexual issues with couples and counselors' ages ($r = .18, p < .01$). This is a small effect size. The older counselors are, the more willing they are to discuss sexual issues with couples. These results are inconsistent with Harris and Hay's (2008) finding that MFTs' age did not influence their willingness to initiate sexual discussions with clients. More research should be conducted to examine this relationship to see if other variables, other than age and counselors' willingness to discuss sexual issues with couples, might cause this correlation. As it was a small effect, the correlation could be due to sample differences as well. A willingness to discuss sexuality may come with age, but it may also be due to the fact that older counselors lived through the sexual revolution.

Sexual discussion with couples and graduate specialization.

A comparative analysis revealed that counselors' willingness to discuss sexual issues with couples differed depending on their graduate specializations. These results showed that, depending on the graduate specialization counselors had completed, such as community counseling or marriage and family counseling, they may be more or less willing to discuss sexual issues with couples. One reason for this finding may be that sexuality may not be explored in career counseling or in a student affairs setting as much as it may be in marriage and family counseling or community counseling. More research is needed to explore which specific

graduate specializations are related to an increase in counselors' willingness to discuss sexual issues with couples. No previous research has examined these two variables.

Other variables.

Based on the correlational analysis the following variables did not have statistically significant relationships with counselors' willingness to discuss sexual issues with couples: counselors' sexual attitudes regarding permissiveness, sexual attitudes regarding communion, sexual attitudes regarding instrumentality, sexual attitudes regarding birth control, sexual knowledge, clinical experience with sexual issues, sex, strength of faith, sexual orientation, years of practice, practice setting, type of license, and relationship status. This means that counselors' willingness to discuss sexual issues with couples is related to counselors' sexuality training and education, supervision experience addressing sexuality, age, and graduate specialization regardless of counselors': sexual attitudes regarding permissiveness, sexual attitudes regarding communion, sexual attitudes regarding instrumentality, sexual attitudes regarding birth control, sexual knowledge, clinical experience with sexual issues, sex, strength of faith, sexual orientation, years of practice, practice setting, type of license, and relationship status.

It is interesting that sexual knowledge did not correlate with counselors' willingness to discuss sexual issues with couples in this study, while a relationship was found between these variables in Harris and Hays' (2008) study. My study did find a relationship between counselors' willingness to discuss sexual issues with couples and their sexual education and training experience, but not their sexual knowledge. This may be because counselors' willingness to discuss sexual issues with couples is often due to a counselor's *confidence level* regarding his or her sexual knowledge and his or her ability to assist clients with sexual issues, rather than his or her actual level of sexual knowledge.

Harris and Hays (2008) found that marriage and family therapists' (MFTs) clinical experience was related to their willingness to initiate sexual discussions with clients, and my study did not find a correlation between these two variables. No relationship was found because the increased clinical experience may not have been positive. Counselors with unsuccessful clinical experience working with sexual issues may want to avoid addressing sexuality again. More research should be conducted to examine counselors' willingness to discuss sexual issues with both clients and couples.

Sexual discussion with couples and predictive variables.

A stepwise regression found that the greatest predictor of counselors' willingness to discuss sexual issues with couples was their supervision experience addressing sexuality ($R^2=.144$). The second greatest predictor was a combination of counselors' supervision experience addressing sexuality and their sexual attitudes regarding birth control ($R^2=.163$). Thus, knowing a counselor's supervision experience addressing sexuality and/or his or her sexual attitudes regarding birth control allows one to predict the counselor's willingness to discuss sexual issues with couples. This finding is similar to Harris and Hay's (2008) finding that the strongest predictors for whether or not marriage and family therapists would initiate sexual discussions with their clients were sexuality education and supervision experience with sexual issues. Counselors' supervision experience addressing sexual issues is an under-researched area that should be explored based on these findings.

The following variables were not found to be predictors of counselors' willingness to discuss sexual issues with couples counselors': sexual attitudes regarding communion, sexual attitudes regarding instrumentality, sexual attitudes on permissiveness, training experience in

human sexuality, sexual knowledge, and clinical experience with sexual issues. These variables are not helpful in predicting counselors' willingness to discuss sexual issues with couples.

Table 30 shows which variables were related to sexuality discussion with couples.

Table 30

Correlation and Chi Square Results of Participants' Scores of Sexuality Discussion with Couples Scores

	Sexuality Discussion with Couples Scores	
Sexuality Education Scores	Pearson Correlation	.26*
	Sig. (2-tailed)	.00
Experience in Supervision Scores	Pearson Correlation	.38*
	Sig. (2-tailed)	.00
Age	Pearson Correlation	.18*
	Sig. (2-tailed)	.01
Type of Graduate Specialization	Chi Square	318.7

Limitations

This is a retrospective study and is prone to the influence of the passing of time. Results may be influenced by a participant's retrospective memory and may inaccurately reflect reality. A limitation to this study was that the participants' responses may not have been accurate. In any survey design, the possibility of false reporting exists. Participants may not have responded accurately for any number of reasons. Due to the belief that counselors should be sensitive to their clients' needs and empathic to any of their presenting issues, participants may have answered the questionnaire with "socially acceptable" responses. They may have responded as the counselors whom they would like to be, not as the counselors they actually are. Due to the sensitive nature of the topic of sex, some participants may have chosen not to answer questions they felt were too personal. Similarly, more sexually conservative individuals may have chosen not to participate because they were uncomfortable with the topic. It's very likely that these

individuals are uncomfortable addressing sexual issues with their clients, and the absence of their data in this study may affect the results. There was an error in the survey when it was sent. Two of the items of the *Sexuality Education Scale* were not included. The scale required that the participants “check all that apply” to their sexuality education experience. The following items were accidentally removed: “Sexuality training was integrated throughout my curriculum,” and “I have taught a graduate course on sexuality.” This may have compromised the integrity of the scale and influenced the results. Because I surveyed ACA members, I may have included a higher number of participants who are LPCs and not LMFTs. Another limitation is that it is very possible that many of the counselors on the ACA email list I purchased did not work with couples. Another limitation of this study was that it was correlational. Therefore, I was not able to make cause and affect inferences based on the results.

Implications for Counselors, Counselor Educators, and Supervisors

Sexual comfort and sexual discussion with couples.

This study has several implications for counselors and counselor educators. Because the study showed that counselors’ sexual comfort and willingness to discuss sexual issues with couples are positively correlated, we know that as sexual comfort increases, so does the likelihood that a counselor will discuss sexual issues with couples he or she counsels. Therefore, in order to increase counselors’ willingness to discuss sexual issues with couples, and in turn provide better services to their clients, counselors should work to increase their sexual comfort levels (Anderson, 2002; Harris & Hays, 2008; Roche, 1998). In addition, counselor educators should focus on ways to improve counselors’ in training sexual comfort. The question then becomes: How we can improve counselors’ and counselors’ in training sexual comfort levels? Many of the variables measured in my study were found to have relationships with both sexual comfort and counselors’ willingness to discuss sexual issues with couples.

Sexuality education and training.

The results of my study showed that the single greatest predictor of counselors' sexual comfort was counselors' human sexuality education and training experience. In addition, a relationship was found between counselors' willingness to discuss sexual issues with couples and their human sexuality education and training experience. Based on these findings, the following inference can be made: If counselor educators incorporate more human sexuality education and training in their programs, students' sexual comfort levels and willingness to discuss sexual issues with couples will increase (Anderson, 1986; Landis et al., 1975; Weerakoon & Stiernborg, 1996). Counseling programs could offer required courses or electives in human sexuality. The subject of human sexuality also seems to be neglected by CACREP. The subject could be emphasized more in terms of training requirements for CACREP programs. Counselors could also improve their own sexual comfort levels and willingness to discuss sexual issues with couples by attending workshops on human sexuality and furthering their education on the subject (Fyfe, 1980; Landis et al., 1975).

Supervision experience addressing sexuality.

The study revealed that counselors' supervision experience addressing sexual issues was related to both counselors' sexual comfort levels and their willingness to discuss sexual issues with couples. Therefore, when supervisors address sexuality with their supervisees, supervisees are more comfortable with sexuality and are more willing to discuss sexual issues with couples. This has implications for counselor educators and supervisors. Counselor educators' and supervisors' roles often involve modeling. They have the opportunity to model for their supervisees the appropriate ways to introduce and explore the topic of sexuality. Counseling programs should encourage faculty supervisors to incorporate sexuality into their supervision.

licensed professional counselor supervisors (LPC-S) can also examine sexuality with their supervisees. Supervision and training regarding human sexuality can focus on counselors' and counselors' in training own biases, beliefs, and attitudes regarding sexuality and sexual practices (Harris & Hays, 2008).

Sexual attitudes.

Counselors' sexual attitudes were also found to be related to both counselors' sexual comfort and their willingness to discuss sexual issues with couples. The second greatest predictor of counselors' willingness to discuss sexual issues with couples, in combination with supervision experience addressing sexuality, was counselors' sexual attitudes regarding birth control. Sexual attitudes regarding communion or idealistic sexuality were found to be related to counselors' sexual comfort. Counselors' sexual attitudes regarding communion or idealistic sexuality, instrumentality or biological sexuality, and permissiveness or casual sexuality were all found to predict counselors' sexual comfort. According to Giami and Pacey (2006), if counselors work to explore their own sexual attitudes and biases, they can potentially increase their sexual comfort levels and willingness to discuss sexual issues with couples. Counselor educators and supervisors can help their students explore their attitudes regarding sexuality to help improve their students' willingness to discuss sexuality with couples and their sexual comfort levels (Giami & Pacey, 2006).

Previous research has suggested ways for counselors to explore their sexual attitudes and for counseling programs to incorporate human sexuality training into programs through a variety of teaching methods. Counselors educators could choose to incorporate any of these teaching methods. Suggested teaching methods to increase human sexuality training and education for counselors and counselors in training are listed below.

Teaching methods.

Weerakoon and Stiernborg (1996) found that healthcare professional training programs use many different teaching methods in sexual education courses, such as lectures, group discussion, videos, role play, and guest speakers. Of these teaching methods, group discussion was found to be the most common. Students are able to share with each other their sexual knowledge, values, and attitudes. This interaction exposes students to values and attitudes different from their own and aims to increase students' tolerance. Explicit films have been used in sexual education courses since the 1970s. The goal of this technique is to desensitize students and increase their tolerance of others' sexual attitudes and behaviors. The effectiveness of evidence for this method is weak at best. There is some fear that exposing students to these films only causes them to become more strict and narrower in their own beliefs. For example, a homophobic student who sees a video of homosexuals engaging in sexual behaviors may become even less tolerant and may very well become more entrenched in his or her homophobia (Weerakoon & Stiernborg, 1996). This may, in turn, result in a hindrance when working with homosexual patients. Although much research supports the method of using explicit films in the sexual education of healthcare professionals, there may be some drawbacks, according to Weerakoon and Stiernborg.

Sex education programs have found when they pretest students before beginning the program that the students have high levels of sexual knowledge. As a result, more sex education programs have incorporated clinical application of the material. Students explore their own sexual attitudes and practice taking a patient's sexual history or addressing a particular sexual concern of a patient. Programs tend to opt for semester-long courses in human sexuality rather

than workshops in order to incorporate more hands-on approaches to the material (Bonner & Gendel, 1989).

It is necessary for healthcare professionals to complete courses in human sexuality in order to recognize patients' sexual concerns, to provide patients with information regarding their concerns with sensitivity, and to provide proper referrals when necessary. Most human sexuality courses provide students with knowledge of physiology and anatomy and help to improve students' comfort levels with sexuality and sexual issues. Teaching methods include lectures, explicit films, and small group discussion (Mann & Wallace, 1975).

Role play.

Role play has been used by sexual educators to increase students' comfort levels in taking sexual histories or inquiring about a patient's sexual health. Researchers have found that students who have had the opportunity to experience taking a sexual history or observe someone else taking a sexual history increase their knowledge and comfort levels in performing the task (Weerakoon & Stiernborg, 1996). A shift occurred in sexual education in the 1990s, from using only desensitization methods to utilizing several different teaching methods that include small group discussions (Weerakoon & Stiernborg, 1996). One problem that occurs in incorporating sexual education into existing healthcare professional training programs' curriculums is that the curriculums are already filled with so many required courses. For this reason, human sexuality is often offered only as an elective or workshop, if at all.

Although healthcare professionals generally understand the importance of addressing sexuality with patients, discussing sexual issues with patients can be anxiety-provoking and embarrassing for both healthcare professionals and patients (Giami & Pacey, 2006). That is why it is important for healthcare professionals to both learn factual information about human

sexuality and practice discussing sexual issues with patients. Through role play exercises, healthcare professionals can become more comfortable initiating sexual discussions and hearing explicit sexual details from patients. This helps healthcare professionals improve their skills in treating their patients' sexual problems. These role play exercises build healthcare professionals' confidence and self-efficacy in dealing with patients' sexual concerns. Self-awareness and self-acceptance are essential qualities for healthcare professionals in order to provide their patients with quality sexual health care (Giami & Pacey, 2006).

Small group discussion.

Attitudes, values, and feelings should be the main focus of sexual education. The best way to explore sexual feelings, attitudes, and values is through small group discussion. There will likely be conflicting values in a group setting. When an individual's values are in conflict, he or she is forced to explore his or her own beliefs and make adjustments if necessary. The small group experience can very well lead to tolerance of others' sexual values, attitudes, beliefs, and respect for their feelings. It is important for sex educators to model sexual comfort for their students. Instructors must be willing to deal openly and honestly with sexuality and address all aspects of sexuality (Cross, 1991).

Integration of multiple teaching methods.

Researchers do not believe that one single teaching method is superior to others, but that a combination of teaching methods is more effective (Weerakoon & Stiernborg, 1996). Research lacks consensus on what constitutes the best combination of teaching methods for human sexuality. According to Bonner and Gendel (1989), an integrative approach using different teaching methods seems to be effective with students. Sex education programs have moved from using sexually explicit materials and implosion methods to using small group discussions in

which students increase awareness of sexual attitudes, beliefs, and biases (Bonner & Gendel, 1989). These teaching methods are useful when training healthcare professionals and counselors in human sexuality.

In the literature, there are various human sexuality teaching modalities for counselors (Anderson, 1986). In addition, I have explored a variety of courses, workshops, and teaching methods created to educate counselors in human sexuality and sexuality counseling (Anderson, 1986; Christensen, Norton, Salisch, & Gull, 1977; Fyfe, 1980; Humphrey, 2000; Landis et al., 1975). I see a general issue in the lack of sexual education in counselor education programs (Ford & Hendrick, 2003; Gray et al., 1989; Hilton, 1997). Although some programs have human sexuality courses, the courses are not consistent between programs. Until CACREP requires programs to offer a course on human sexuality as either a required or elective course, I believe counselors in training will enter the counseling profession unprepared to work with clients with sexual issues. Students need education, training, and supervision experience in sexual issues in order to work effectively with clients with sexual concerns.

Landis et al. (1975) have recommended that counselors complete a Sexual Awareness Training (SAT) seminar to increase sexual knowledge. The purpose of this seminar is for counselors to explore their own sexual attitudes, behaviors, and feelings. Although the seminar is education-oriented, the main goal is for counselors to become more sexually self-aware. As a result, counselors can create non-judgmental environments for their clients. The SAT seminar is completed over a weekend and involves 14-18 hours of training. The training includes films, lectures, and small and large group discussions. Based on the seminar evaluations, participants have rated the training very positively. One participant reported, after the experience, that he or she expected to be able to discuss sexual issues without being uncomfortable or embarrassed.

Another reported that the seminar helped him or her to explore some of his or her own sexual issues that may have inhibited his or her ability to provide his or her clients with appropriate care. Most participants predicted that they would be better equipped to deal with their clients' sexual concerns (Landis et al., 1975). According to Landis et al., regardless of the type of sexual issues a client presents with, counselors will be able to better serve their clients if they have an awareness of their own sexuality and sexual values, attitudes, and beliefs.

There are a variety of different ways to help educate and train counselors in human sexuality. I hope that based on the findings of this study, counselors and counselor educators will work to improve their students' and their own sexual comfort levels and willingness to discuss sexual issues with couples.

Counselor's age.

The study found that both counselors' sexual comfort and willingness to discuss sexual issues with couples correlated with counselors' age. Although this is an interesting finding, it has little implication for counselors or counselor educators. No one can change his or her age; however, it does imply that the older a counselor may be, the more comfortable he or she is with sexuality and the more likely he or she is to discuss sexual issues with couples. Another variable with few implications that correlated with counselors' sexual comfort was counselors' years of experience, which seems to be linked to age because, generally, the longer a counselor has been practicing, the older he or she is. However, a counselor can only increase his or her years of experience as time passes, so this variable has few implications for counselors and counselor educators.

Graduate specialization.

The final relationship in the study with implications for counselors and counselor educators was found between counselors' willingness to discuss sexual issues with couples and their types of graduate specialization. The results suggest that, depending on the type of graduate specialization a counselor has completed, he or she may be more likely to discuss sexual issues with couples. More research needs to be conducted to explore which specializations show an increase in counselors' willingness to discuss sexual issues with couples. Then, based on these results, counselor educators could examine what these particular specializations are teaching that is improving counselors' willingness to discuss sexual issues with couples.

My hope is that the implications of this study will encourage counselor educators and supervisors to increase education and human sexuality training in their programs, incorporate sexuality into supervision sessions, encourage students to explore their sexual attitudes, and examine their graduate specializations in efforts to improve counselors' sexual comfort levels and willingness to discuss sexual issues with couples.

Person-centered theory.

Roger's person-centered theory, which was the theoretical framework for this study, can be used to help guide counselors, counselor educators and supervisor to improve their own and their students' sexual comfort levels and willingness to discuss sexual issues with couples. Rogers (1977) believed that the purpose of therapy is not to fix clients' problems. Instead, the counselor should help clients to grow and work towards self-actualization so that they might be more equipped to handle their own problems in the future without the assistance of a counselor (Rogers, 1977). According to Rogers, counselors should observe the following characteristics in

their clients as they grow and become more self-actualized: increased trust in themselves, openness to new experiences, self-evaluation, and a desire to continue learning and growing (Rogers, 1961). Research has shown that the relationship a client builds with a counselor provides the greatest possibility for change in the client (Raskin & Rogers, 2000). Because the counselor-client relationship is so important, it is the counselor's responsibility to create a safe environment. Because a counselor's own attitudes and beliefs so greatly affect this environment, it seems rather important that the counselor be self-actualized, as well (Andrews, 2000; Rogers, 1951). In order for a counselor to be self-actualized, he or she must be comfortable with his or her own sexuality. It seems that the field has neglected human sexuality as a topic in counseling and in the education and training of counselors. Counselors, counselor educators, and supervisors could all benefit from: increased trust in themselves, openness to new experiences, self-evaluation, and a desire to continue learning and growing. The findings in this study helped to illuminate an area in the field in which there is room to grow and improve. Focusing growth efforts in the field on providing human sexuality training, education, and supervision to counselors will help them to work towards self-actualization. The final outcome would be improved quality of services to clients.

Practice implications.

If counselors, counselor educators, and supervisors strive to improve counselors' willingness to discuss sexual issues with couples and sexual comfort levels, couples' counselors and counselors for clients with sexual concerns will likely provide better care to their clients. Many clients have some form of sexual issue, ranging from body image issues to abuse or trauma, and it is important for clients to work on these issues. It is detrimental to a client if a counselor is not willing to explore these issues due to the counselor's own anxiety, discomfort,

or lack of training on the topic (Hilton, 1998). Negative outcomes associated with ignoring sexual issues include divorce, anxiety, and depression (Gray et al., 1989). Counselors, counselor educators, and supervisors have an opportunity to utilize the findings of this study to improve services provided to clients.

Implications for Future Research

Based on the findings of this study, I suggest that future research further explore the relationship between counselors' sexual comfort and willingness to discuss sexual issues with couples and counselors' age. This relationship may be affected by the fact that the older a counselor may be, the longer he or she has probably been practicing and the more experience he or she has. This relationship may be due to a generational difference rather than an age difference. Older counselors today lived during the sexual revolution. This may be the underlying reason for their comfort level with sexuality, rather than the fact that they are older. More research should be conducted to explore these findings.

Additional research should explore the relationship between counselors' willingness to discuss sexual issues with couples and counselors' types of graduate specialization. A better understanding of which types of graduate specializations lead to counselors' greater willingness to discuss sexual issues with couples has real implications for counselors and counselor educators.

The study revealed that counselors' supervision experience addressing sexual issues was related to both counselors' sexual comfort and their willingness to discuss sexual issues with couples. Harris and Hays (2008) had similar findings in their study. However, Harris and Hays were the first to empirically test these relationships. My study used the same scale to measure counselors' supervision experience with sexuality. Further research should be conducted to examine these variables because they have strong implications for counselor educators and

supervisors. Future studies should examine these variables using different instruments of measure to see if the results are consistent.

My study found a significant relationship between counselors' strength of faith, regardless of religion, and their sexual comfort levels. These results were significant only at the .05 level and were not valid for this study. However, further research should be conducted on these variables to measure this relationship.

Counselors' clinical experience working with sexual issues and their willingness to discuss sexual issues with couples was also correlated at the .05 level and was not valid for the purpose of this study because of the conservative alpha level which was set. More research should be conducted to examine the relationship between these two variables to see if a relationship truly exists.

Permissiveness, birth control, communion, and instrumentality were the aspects of sexual attitudes that were measured in this study. Although few correlations were found between these variables and the dependent variables, sexual comfort and sexual discussion with couples, they were found to be predictive variables for sexual comfort and sexual discussion with couples. Sexual attitudes regarding permissiveness, communion, and instrumentality were found to be predictive variables of sexual comfort, and sexual attitude regarding birth control was found to be a predictive variable of counselors' willingness to discuss sexual issues with couples. The many different types of sexual attitudes seem to have interesting relationships with sexual comfort and willingness to discuss sexual issues. Therefore, future studies should further examine these relationships. The implications of a study that further examines these variables in that it would help counselor educators focus on specific aspects of students' sexual attitudes to address.

Based on the implications of this study, future research should examine more effective ways to incorporate human sexuality education, training, and supervision into counseling programs. This empirical research could then be used to encourage CACREP to require human sexuality education and training in counseling programs.

Finally, qualitative studies exploring counselors' experience working with couples and sexuality would add to the empirical data on the topic.

Conclusions

Sexuality is an important aspect of our lives that should not be neglected in the course of therapy. Sex is an especially important aspect in a marriage because of its influence on overall marital satisfaction (Byers, 2005; Donnelly, Guo & Huang, 2005; Hatfield, Greenberger, Traupmann, & Lambert, 1982; McCabe, 1999). Therefore, directly addressing sexual issues with clients is important for couples' counselors. If counselors avoid discussing these issues, they run the risk of hindering client growth (Hilton, 1997). Thus, it is important for counselors to feel comfortable with sexuality and to be willing to discuss sexual issues with couples in the course of therapy. This study has helped point to the factors that are associated with counselors' sexual comfort and willingness to discuss sexual issues with couples. The implications of this study can be used by counselors and counselor educators to improve services provided in couples' counseling.

This study found that counselors' sexual education and training experience, supervision experience discussing sexuality, sexual attitudes, and age were all associated with both counselors' sexual comfort and willingness to discuss sexual issues with couples. Counselors' years of practice were found to be associated with their sexual comfort levels. Types of graduate specialization were found to be associated with counselors' willingness to discuss sexual issues with couples. These results have implications for counselors, counselor educators, and

supervisors. It is hoped that the results of this study will help to inspire counselors, counselor educators, and supervisors to improve their own, their students', and their supervisees' sexual comfort levels and willingness to discuss sexual issues with couples.

References

- Anderson, M. J. (2002). *Counselor comfort with sexual issues*. Unpublished doctoral dissertation, University of New Orleans, New Orleans, LA.
- Anderson, W. (1986). Stages of therapist comfort with sexual concerns of clients. *Professional Psychology: Research and Practice*, 17(4), 352-356.
- Andrews, W. C. (2000). Approaches to taking a sexual history. *Journal of Women's Health & Gender-Based Medicine*, 9, 21-24.
- Arnold, R. L. (1980). *A study of the sexual attitudes, knowledge and experience of counselors in training and the effect of these factors on counselor reaction to client sexual concerns*: Unpublished doctoral dissertation, University of Northern Colorado, Greeley, CO.
- Babbie, E. (1990). *Survey research methods*. Belmont, CA: Wadsworth
- Bernard, J. M., & Goodyear, R. K. (2004). *Fundamentals of clinical supervision* (3rd ed.). Boston, MA: Pearson Education, Inc.
- Bonner, E. J., & Gendel, E. S. (1989). Sex education in medicine: Implications for family life education. *International Journal of Adolescent Medicine and Health*, 4, 203-212
- Byers, E. (2005). Relationship satisfaction and sexual satisfaction: A longitudinal study of individuals in long-term relationships. *The Journal of Sex and Research*, 42(2), 113-118.
- Corey, G. (2005). *Theory and practice of counseling and psychotherapy* (7th ed.). Belmont, CA: Brooks/Cole Thomson Learning.
- Council for Accreditation of Counseling and Related Educational Programs (CACREP). 2009 *Standards*. Available online <http://www.cacrep.org/2009standards.html>.
- Cross, R. J. (1991). Helping adolescents learn about sexuality. *SIECUS Report*, 19, 6-11.

- Donnelly, D. (1993). Sexually inactive marriages. *Journal of Sex Research, 30*(2), 171-179
- Ducharme, S., & Gill, K. M. (1990). Sexual values, training, and professional roles. *The Journal of Head Trauma, 5*, 38-45.
- Estrada, A. U., & Holmes, J. M. (1999). Couples' perceptions of effective and ineffective ingredients of marital therapy. *Journal of Sex and Marital Therapy, 25*, 151-162.
- Ford, M. P., & Hendrick, S. S. (2003). Therapists' sexual values for self and clients: Implications for practice and training. *Professional Psychology: Research and Practice, 34*, 80-87.
- Fluharty, L. B. (1995). *The effects of sexual knowledge, professional status, and client gender, on male and female therapists' comfort with client-presented sexual material.* Unpublished doctoral dissertation, University of Akron, Akron, OH.
- Fyfe, B. (1980). Counseling human sexuality: A training model. *Personnel and Guidance Journal, 59*(3)147-150.
- Giami, A., & Pacey, S. (2006). Training health professionals in sexuality. *Sexual and Relationship Therapy, 21*(3), 267-271.
- Gough, H. G. (1974). A 24-item version of the *Miller-Fisk Sexual Knowledge Questionnaire.* *The Journal of Psychology, 87*, 183-192.
- Graham, C. A., & Smith, M. M. (1984). Operationalizing the concept of sexuality comfort: Applications for sexuality educators. *Journal of School Health, 54*(11), 439-442.
- Gray, L. A., Cummins, E. J., Johnson, B. P., & Mason, M. J. (1989). Human sexuality instruction in counselor education curricula. *Counselor Education and Supervision, 28*, 305-316.

- Guldner, C., & Guldner, D. (1992). Sexual issues arising within the course of couple therapy. *The Canadian Journal of Human Sexuality, 1*(2), 55-65.
- Guo, B., & Huang, J. (2005). Marital and sexual satisfaction in Chinese families: Exploring the moderating effects. *Journal of Sex and Marital Therapy, 31*, 21-29.
- Haboubi, N., & Lincoln, N. (2003). Views of health professionals on discussing sexual issues with patients. *Disability and Rehabilitation, 25*(6), 291-296.
- Harris, S. M., & Hays, K. W. (2008). Family therapist comfort with and willingness to discuss client sexuality. *Journal of Marital and Family Therapy, 34*(2), 239-250.
- Hatfield, E., Greenberger, D., Traupmann, J., & Lambert, P. (1982). Equity and sexual satisfaction in recently married couples. *The Journal of Sex Research, 18*(1), 18-32.
- Hautamaki, K., Miettinen, M., Kellokumpu-Lehtinen, P., Aalto, P., & Lehto, J. (2007). Opening communication with cancer patients about sexuality-related issues. *Cancer Nursing an International Journal for Cancer Care, 30*(5), 399-404.
- Hays, K. (2008). *The influence of sexuality education and supervision, clinical experiences, perceived knowledge, and comfort with sexual content on therapist addressing sexuality issues with clients*: Unpublished doctoral dissertation, Texas Tech University, Lubbock, TX.
- Hedgepeth, E. M. (1988). *Sexuality comfort: Its measurement and relationship to other variables in sexuality education*: Unpublished doctoral dissertation, the Union for Experimenting Colleges and Universities, Cincinnati, OH.
- Hendrick, C., Hendrick, S., & Reich, D. (2006). The Brief Sexual Attitudes Scale. *Journal of Sex Research, 43*(1), 76-87.

- Hilton, V. W. (1997). Sexuality in the therapeutic process. In L. Hedges, R. Hilton, W. V. Hilton & B. Caudill (Eds.). *Therapists at risk: Perils of the intimacy of the therapeutic relationship*, (pp. 181-220). Northvale, NJ: Jason Aronson.
- Christensen, E. W., Norton, J. L., Salisch, M., & Gull, S. (1977). An affective sexual awareness program for counselors. *Counselor Education and Supervision*, 16, 185-193.
- Humphrey, K. M. (2000). Sexuality counseling in counselor preparation programs. *The Family Journal: Counseling and therapy for Couples and Families*, 8, 305-308.
- Jones, M. K., Weerakoon, P., & Pynor, R. A. (2005). Survey of occupational therapy students' attitudes towards sexual issues in clinical practice. *Occupational Therapy International*, 12(2), 95-106.
- Karlen, A., & Moglia, R. (1995). Sexuality, aging, and the education of health professionals. *Sexuality and Disability*, 13(3), 191-199.
- Kirkpatrick, J. S. (1980). Human sexuality: A survey of what counselors need to know. *Counselor Education and Supervision*, 19, 276-282.
- Landis, C. E., Miller, H. R., & Wettstone, R. P. (1975). Sexual awareness training for counselors. *Teaching of Psychology*, 2(1), 33-36.
- Mann, J., & Wallace, D. (1975, August). *Effects of brief training in sex counseling on attitudes and behaviors of health professionals*. Paper presented at the Annual Convention of the American Psychological Association, Chicago, IL.
- Maslow, A. (1965, May). *Self-Actualization and Beyond*. Paper presented at the Conference on the Training of Counselors of Adults, Chatham, MA.
- Masters, W. H., & Johnson, V. E. (1970). *Human sexual inadequacy*. Boston, MA: Little, Brown & Company.

- McCabe, M. (1999). The interrelationship between intimacy, relationship functioning, and sexuality among men and women in committed relationship. *The Canadian Journal of Human Sexuality*, 8, (1), 31-38.
- McConnell, L. G. (1976). An examination of the counselor's skills when counseling clients with sexual problems. *The Family Coordinator*, 25, 183-188.
- Meisel, S. S. (1977). The treatment of sexual problems in marital and family therapy. *Clinical Social Work Journal*, 5(3), 200-209
- Nathan, S. G. (1986). Are clinical psychology graduate students being taught enough about sexuality? *Journal of Sex Research*, 22, 520-524.
- Prochaska, J. O., & Norcross, J. C. (2007). *Systems of psychotherapy a transtheoretical analysis* (6th ed). Belmont, CA: Thomas Brooks/Cole.
- Raskin, N., & Rogers, C. (2000). Person-centered therapy. In R. J. Corsini & D. Wedding (Eds.), *Current psychotherapies* (pp. 133-167). Itasca, IL: Peacock.
- Roche, B. F. (1998). A study of relationships among human sexuality education, sexual comfort, HIV knowledge, and willingness of high school counselors to respond to adolescents about sexual issues. *Dissertation Abstracts International*, 58-12A, 4571.
- Rogers, C. R. (1942). *Counseling and psychotherapy: Newer concepts in practice*. Boston, MA: Houghton Mifflin.
- Rogers, C. R. (1951). *Client-Centered therapy: Its current practice, implications, and theory*. Boston, MA: Houghton Mifflin Company.
- Rogers, C. (1961). *On becoming a person*. Boston, MA: Houghton Mifflin Company.
- Rogers, C. (1977). *Carl Rogers on personal power: Inner strength and its revolutionary impact*. New York, NY: Delacorte Press.

- Seligman, L. (2004). *Diagnosis and treatment planning in counseling* (3rd ed.). New York, NY: Kluwer Academic Publishers.
- Spicer, J. (2005). *Making sense of multivariate data analysis*. Thousand Oaks, CA: Sage Publications, Inc.
- Sprencer, S. (1998). Social exchange theories and sexuality. *The Journal of Sex and Research*, 35, (1), 32-43.
- Stayton, W. R. (1998). A curriculum for training professionals in human sexuality using the Sexual Attitude Restructuring (SAR) model. *Journal of Sex Education and Therapy*, 23, 26-32.
- Weerakoon, P., Jones, M.K., Pynor, R., & Kilburn-Watt, E. (2004). Allied health professional students' perceived level of comfort in clinical situations that have sexual connotations. *Journal of Allied Health*, 33(3), 189-193.
- Weerakoon, P., & Stiernborg, M. (1996). Sexuality education for healthcare professionals: A critical review of the literature. *Annual Review of Sex Research*, 7, 181-218.
- White, S. D., & DeBlassie, R. R. (1992). Adolescent sexual behavior. *Adolescence*, 27(105), 183-217.
- Wicks, R. J., Parsons, R. D., Capps, D. (1993). *Clinical handbook of pastoral counseling. Volume one (Expanded ed.)*. New York, NY: Paulist Press.

Appendix A

Permission to use Instruments

Sexuality Education Scale, Experience in Supervision Scale, Clinical Experience Scale, and the Sexuality Discussion with Clients Scale:

To: ["rawieck@loyno.edu" <rawieck@loyno.edu>](mailto:rawieck@loyno.edu) **Date:** Tue, 28 Oct 2008 08:17:11 -0600
Subject: RE: Request for Information **Status:** Normal
CC: **From:** ["Harris, Steve" <steve.harris@ttu.edu>](mailto:Harris, Steve)
Reply-to: ["Harris, Steve" <steve.harris@ttu.edu>](mailto:Harris, Steve)

Rachel,

Glad to hear of your interest in this topic. Feel free to use the scales we developed or tweak them to your specific needs, just make sure to give us credit in your document as well as in further research. You'll want to make sure you report the reliability stats on any scales you create.

The Graham and Smith scale was something we created based on an article they authored. It would be a good idea for you to access the dissertation that Kelli Hays did (the original document). It will give you all the info you need on the scales. The article version will be much briefer.

Let me know if you have any other questions. Best of luck to you. Let's talk if you'd like.

Steve

Steven M. Harris, Ph.D., LMFT
Professor - Marriage and Family Therapy
Texas Tech University
Box 41210
Lubbock ,TX 79409-1210

806.742.5050 X 261
806.742.5033 fax

-----Original Message-----

From: rawieck@loyno.edu [rawieck@loyno.edu]
Sent: Thursday, October 23, 2008 1:14 PM
To: Harris, Steve
CC: iparadis@uno.edu
Subject: Request for Information

Dear Dr. Harris,

I am a doctoral student in Counselor Education at the University of New Orleans. I am in the beginning stages of my dissertation research. My Masters degree is in Marriage and Family Counseling and my research interest tend to focus of couples and sexuality. For my dissertation, I was interested in researching therapist comfort level discussing sexuality with couples in marital therapy. I have read many articles on the influence sexual satisfaction has on marital satisfaction. I figured since it is such an important aspect of marriage it should be addressed in counseling.

My research on the topic led me to your article "Family Therapist Comfort with and Willingness to Discuss Client Sexuality". Your article took my idea one step further and explored therapist knowledge of human sexuality. For my dissertation I would like to continue to further explore this topic. In your article you suggested that future research should investigate "the influence of clinical supervision on therapists' initiating sexuality-related discussions".

I would like to explore counselors' experience of discussing sexuality with their supervisors. I would like your permission to utilize the scales used in your study. Based on where my study leads me I may be making some additions or changes to your scales. I would also like to find out how you were able to access Graham and Smith's Sexual Comfort Scale. Any assistance you can offer me would be greatly appreciated.

I am very impressed and motivated by your research. I would appreciate any suggestions or feedback for my dissertation. Thank you for your time. Please contact me at your earliest convenience at (615)364-9002 or rwieck@uno.edu.

Rachel Wieck, LPC Intern, NCC
Executive Assistant to the Chair
Loyola University Counseling Department
(504)864-7857
rawieck@loyno.edu

Subject: permission to use SCI
CC:
Reply-to: ["Evonne Hedgepeth"](mailto:Evonne.Hedgepeth@lifespaneducation.com)
<evonne@lifespaneducation.com>

Date: Thu, 30 Jul 2009 22:34:25 -0600
Status: 3
From: ["Evonne Hedgepeth"](mailto:Evonne.Hedgepeth@lifespaneducation.com)
<evonne@lifespaneducation.com>

Hello, Rachel:

I have received your check for \$50.00. Thank you for sending it.

My understanding is that you are working on your dissertation at the
> University of New Orleans in order to receive your Ph.D.
> in Counselor Education. Your study is on Counselors'
> sexual comfort and willingness to discuss sexual issues
> with couples they are counseling.

You have my permission to use:
> Part I of the Sexuality Comfort Instrument I created for my
> dissertation in your study.

I wish you good luck in the completion of this important study and in writing your dissertation. I trust that at the conclusion of your study you will share with me a brief summary of your findings (your abstract will do), as I will be very interested to hear about how it turns out.

Best wishes,
Evonne Hedgepeth, Ph.D.
Lifespan Education
360-352-9980

From: Hendrick, S [mailto:s.hendrick@ttu.edu]
Sent: Thu 10/8/2009 10:39 AM
To: Rachel Wieck
Cc: Hendrick, Clyde
Subject: RE: The Brief Sexual Attitudes Scale

Rachel,

You are welcome to use the BSAS. A copy is attached for your convenience. Best of luck in your work.
Susan

From: Rachel Wieck [mailto:rawieck@loyno.edu]
Sent: Wednesday, October 07, 2009 4:33 PM
To: Hendrick, S
Subject: The Brief Sexual Attitudes Scale

Dr. Hendrick,

I am a Doctoral Candidate at the University of New Orleans in their Counselor Education program. I am currently working on my dissertation which is on Counselors' Comfort and Willingness to Discuss Sexual Issues with Couples. I am interested in using your Brief Sexual Attitudes Scale in my dissertation research. I will be sending the scale out electronically using qualtrics.com to members of the American Counseling Association (ACA). How can I receive permission to use the scale? Any assistance would be greatly appreciated. Thank you for your help.

Have a great day!

Rachel Wieck, PhD Candidate, LPC Intern
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November 11, 2009

Rachel Wieck, LPC Intern, NCC
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Dear Rachel,

Gough, H.G. "Figure/Table: A 24-item version of the Miller-Fisk Sexual Knowledge Questionnaire." *The Journal of Psychology*, 87 (1974): 183-192.

Thank you for your correspondence requesting permission to reproduce the 24-item version of the Miller-Fisk Sexual Knowledge Questionnaire in your forthcoming dissertation.

We will be pleased to grant you permission free of charge on the condition that:

This permission is limited to non exclusive English language (print/electronic) rights for this usage only.

This permission does not cover any third party copyrighted work which may appear in the material requested.

No alterations may be made to our work without written consent.

All reasonable efforts must be made to contact the author(s) to notify them of your intentions and confirm they are happy with the permission being granted.

Full acknowledgement must be included showing article title, author, full Journal title, date of publication and publisher (Taylor & Francis Ltd, <http://www.informaworld.com>), reprinted by permission of the publisher.

Thank you for your interest in our Journal.

Sincerely,

Tim Legnani

Journal Sales Administrator
Permissions Coordinator

HARRISON G. GOUGH, PH. D.
P.O. Box 909
Pebble Beach, CA 93953
October 1, 2009

Ms. Rachel Wieck
6525 Gladys Street
Metairie, LA 70003

Dear Ms. "Wieck:

This letter gives you my permission to reproduce copies and to use the 24-item Sexual Knowledge Questionnaire in your research project.

The primary report on the scale is my article in the *Journal of Psychology*, 1974, vol. 87, pp. 183-192. A copy of this article is enclosed. I am also enclosing a copy of the SKQ, as I and my colleagues at the University of California and elsewhere have used it.

In the late 1970s, I directed a program of studies on birth planning and related topics, at the University of California. A bibliography of published reports stemming from this project, and doctoral dissertations, is enclosed. On the bibliography I have put check marks in front of those reports conveying information on the SKQ. If your library carries these journals, I suggest that you read the articles.

Three of the articles are in Italian, published in Italian journals. Few American libraries will have these journals available. In my own files here in Pebble Beach I was able, to find only one of them, #15. I have made a copy of this article for you as it reports some correlational data for the SKQ (in Table 5). Good luck on your study. When you are finished please send me the bibliographic listing (in case SKQ data are reported). If this report is a masters or doctoral thesis, please give title of the thesis, degree granted, year of receipt, college granting the degree, and if possible a brief summary or abstract of your findings.

Sincerely,

HARRISON G. GOUGH

Appendix B

IRB Approval

***University Committee for the Protection
of Human Subjects in Research
University of New Orleans***

Campus Correspondence

Principal Investigator: Louis Paradise
Co-Investigator: Rachel Wieck
Date: November 9, 2009
Protocol Title: "Counselors' Comfort Level and Willingness to Discuss
Sexual Issues with Couples They Counsel"
IRB#: 16Dec09

The IRB has deemed that the research and procedures described in this protocol application are exempt from federal regulations under 45 CFR 46.101 category 2, due to the fact that the information obtained is not recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects.

Exempt protocols do not have an expiration date; however, if there are any changes made to this protocol that may cause it to be no longer exempt from CFR 46, the IRB requires another standard application from the investigator(s) which should provide the same information that is in this application with changes that may have changed the exempt status.

If an adverse, unforeseen event occurs (e.g., physical, social, or emotional harm), you are required to inform the IRB as soon as possible after the event.

Best wishes on your project.
Sincerely,

Robert D. Laird, Ph.D., Chair
UNO Committee for the Protection of Human Subjects in Research

Appendix C

ACA Approval to purchase email list

Good morning Rachel. Good news, your paperwork has been approved.

I just need to double check with you as to what you are requesting for your research. On your fax you mentioned 2,000 ACA members email addresses. Did you want a random selection of members (to include students, retired, new professionals)? Any foreign records?

The total cost for this would be: \$350 (\$200/1,000 plus \$150 for additional 1,000 records). I will need to get a credit card number or a check from you before I place your request.

Thank you, I look forward to hearing from you soon.

Rae Ann

Rae Ann Sites
Member Programs Coordinator
American Counseling Association
5999 Stevenson Avenue
Alexandria, VA 22304
703/823-9800, ext 217 (o); 800/347-6647, ext. 217
703/823-0252 (fax) or 800/473-2329
www.counseling.org

Appendix D

Email Requesting Participation

Dear Counselors:

I am a Doctoral student under the direction of Professor Louis V. Paradise in the Department of Educational Leadership, Counseling and Foundations at the University of New Orleans. I am conducting a research study to examine counselors' comfort level and willingness to discuss sexual issues with couples they counsel.

I am requesting your participation, which will involve completing a 10-25 minute questionnaire. Your participation in this study is voluntary. Your participation in this study is anonymous. No information will be obtained that would allow me to link responses with individuals. If you choose not to participate or to withdraw from the study at any time, there will be no penalty. If any of the questions in the survey make you feel uncomfortable you may omit the question. The results of the research study may be published, but your name will not be used.

Although there may be no direct benefit to you, the possible benefit of your participation is the findings may benefit counselors, counselors-in-training, counseling preparation programs and counseling professionals.

If you have any questions concerning the research study, please call me or Dr. Louis V. Paradise at (615) 364-9002.

If you are willing to participate please click on the following link:

http://neworleans.qualtrics.com/SE?SID=SV_9RjPCOieaSWU93C&SVID=Prod

Sincerely,

Rachel Wieck, PhD Candidate, LPC Intern
rawieck@loyno.edu
(504)864-7857

Follow this link to the Survey:

[Take the Survey](#)

Or copy and paste the url below into your internet browser:

http://neworleans.qualtrics.com/WRQualtricsSurveyEngine?Q_SS=bmdEKFFKcUpbAsA_9RjPCOieaSWU93C&SVID=Prod

Follow the link to opt out of future emails:

http://neworleans.qualtrics.com/CP/Register.php?OptOut=true&RID=MLRP_3fN2KfwmPy86sLi&ServerID=Prod

Appendix E

Qualitative Data

Participants' responses to:

Please share any additional information you feel is relevant to the topic of counselors' comfort level and willingness to discuss sexual issues with couples in the space provided.

1. It is very awkward, but one ought to learn to tolerate awkward conversations, I suppose.
2. neutral was misspelled on the first scale. Also, there are some older items about sexual knowledge included in here.
3. I find that my comfort level in a counseling setting is very different than the comfort level in my own life. I think I am completely comfortable talking to a couple or individual who is experiencing sexuality issues, although in my own life I am somewhat quiet about it even with my husband.
4. Counselor's previous personal sexual abuse history
5. I think having children, adult children, have educated me much more concerning sexuality. Two of my children are gay, so this experience of accepting them has taught me much about being tolerant and accepting of my client's sexual behaviors and problems.
6. I feel counselors must discuss sex and sexuality with clients just as we discuss any other topic. I think we need to address counselor's discomfort talking about sex/sexuality and the lack of skill in treating sexual issues. It is terrible that most counselors do not feel comfortable in this area. It is just another aspect of human experience.
7. Counselors should strive to be at ease when talking to clients about sexual issues.
8. I rarely work with couples as I work in a college counseling center, and I have very little training in couples work.
9. I am very comfortable counseling couples and individuals on sexual topics.
10. Sex impacts the whole person. Heart (that which we cherish) & Spirit (our relationship with God), Soul (Mind, emotions & will), the Body (physically & chemically) and Relationally.
11. Some of these questions assume heterosexuality. As an individual who does not consider themselves heterosexual, such questions regarding birth control methods and whether men or women should share responsibility for birth control, do not apply. These questions limit the reliability of this survey. As a therapist, you must also consider how your choice of words and questions reflect your heteronormative bias.

12. I am a strong proponent of anything goes between a married man and woman in the privacy of their bedroom as long as both are comfortable. I believe the sexual experience is a part of a healthy marriage. I believe sexual activity should be restricted to marriage. I work with sexual addicts, homosexuals, and marriages struggling with adultery. I do not condemn them, but help them strive for sexual purity within marriage.

13. I am more concerned with feelings than biology. I have seen extremes from no sex to many partners, what is right for one person may be totally wrong for another. It is important to help the client clarify their own values and beliefs in terms of sexuality not impose others' ideas. Only rule - do no harm to self or others.

14. I am a career counselor, so I don't have much reason to discuss sexual issues with my clients. If I was in a different area/field, I wouldn't hesitate to discuss these issues with clients (based on their comfort levels, of course).

15. As a counselor, I look to the client to dictate what he/she is comfortable talking about. I don't feel uncomfortable talking about any things sexual. My difficulty always lies in figuring out how to approach sexual topics with clients in a way that helps them say what they need to say. In my experience, these have often been very religious people who have difficulty.

Vita

Rachel Wieck was born and raised in Nashville, TN. She moved to New Orleans in 2000 to attend Loyola University. She received her BA in Psychology from Loyola in 2004. While her pursuit to help and serve others she attended Our Lady of Holy Cross College. She graduated from Our Lady of Holy Cross College in 2007 with her Masters in Marriage and Family Counseling.

While pursuing her Master's Degree, Rachel worked as an Intern at Trinity Counseling and Training Center and Thomas E. Chambers Counseling Center. Here she had the opportunity to counsel individuals, families, couples, children, and groups. Upon graduating with her Masters, Rachel worked as a Crisis Counselor for Louisiana Spirit. (Louisiana Spirit is a grant funded program that was started to address the mental health needs of those affected by hurricane Katrina.) Rachel's work for Louisiana Spirit focused on counseling the elderly and children. Rachel is currently working on her Ph.D. at the University of New Orleans in Counselor Education. Rachel currently works as the executive Assistant to the chair of the Counseling Department at Loyola University New Orleans. In addition, Rachel serves as adjunct faculty in the counseling department at Loyola University. Her research interest is in couples therapy.