Walden University
A higher degree. A higher purpose.

Walden University
ScholarWorks

Walden Dissertations and Doctoral Studies

Walden Dissertations and Doctoral Studies Collection

2018

Therapists' Attitudes, Knowledge, Comfort, and Willingness to Discuss Sexual Topics with Clients

Byron James Moore
Walden University

Follow this and additional works at: https://scholarworks.waldenu.edu/dissertations


Part of the Counseling Psychology Commons

This Dissertation is brought to you for free and open access by the Walden Dissertations and Doctoral Studies Collection at ScholarWorks. It has been accepted for inclusion in Walden Dissertations and Doctoral Studies by an authorized administrator of ScholarWorks. For more information, please contact ScholarWorks@waldenu.edu.

Walden University

College of Social and Behavioral Sciences

This is to certify that the doctoral dissertation by

Byron J. Moore

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Mary Bold, Committee Chairperson, Human Services Faculty
Dr. Scott Hershberger, Committee Member, Human Services Faculty
Dr. Nicole Hamilton, University Reviewer, Human Services Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

Walden University
2018

Abstract

Therapists' Attitudes, Knowledge, Comfort, and Willingness

to Discuss Sexual Topics with Clients

by

Byron J. Moore

JD, Cleveland State University, 2009

BS, Southern Adventist University, 2005

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Human Services – Family Studies and Intervention Strategies

Walden University

August 2018

Abstract

Empirical literature indicated that marriage and family therapists are not comfortable discussing sexual topics with clients. The purpose of this cross-sectional correlational study was to examine the variables that may influence or predict a therapist's willingness to discuss sexual topics with clients. The research questions focused on understanding the predictive relationship between the independent variables of therapists' (a) attitudes, (b) knowledge, (c) training, (d) supervision experience, (e) clinical experience, (f) sex, (g) age, (h) strength of religion, (i) sexual orientation, (j) practice experience, (k) practice setting, and (l) graduate specialization, and the dependent variables of therapists' (a) willingness to discuss sexual topics with clients and (b) comfort discussing sexual topics with clients. Bowenian theory provided the framework for the study. Survey data were collected from 90 state-licensed marriage and family therapists in the United States. Findings from correlational and stepwise logistic regression analyses indicated that supervision experience was the strongest predictor of a therapist's willingness to discuss sexual topics with a client. The second strongest predictor was clinical experience. Therapists' attitudes and knowledge were not predictors of comfort or willingness to discuss sexual topics with clients. Increasing the number of clinical and supervisory opportunities for marriage and family therapists may increase their willingness to discuss sexual topics and may decrease the number of clients who cannot receive help, which may improve quality of life for therapists, clients, and their families.

Therapists' Attitudes, Knowledge, Comfort, and Willingness to Discuss Sexual Topics with Clients

by

Byron J. Moore

JD, Cleveland State University, 2009

BS, Southern Adventist University, 2005

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Human Services – Family Studies and Intervention Strategies

Walden University

August 2018

Dedication

I dedicate this dissertation to my Lord and Savior Jesus Christ and to Dr. Nathan Leiske.

Acknowledgments

I would like to take this opportunity to thank and acknowledge the following individuals: Dr. Mary Bold, for her incredibly insightful commentary and straightforward manner of communicating and for all of her tireless work assisting me during this process, and Dr. Scott Hershberger, for his perspective, time, and understanding. Lastly, I would like to thank the university research reviewer who lent her time to this project. It was appreciated.

I would like to thank my parents, John and Denise, for their support in providing me the tools to get to this place in my life, and my sister, Chelsea, for her constant pushing of me to see the world in a different light and my grandparents Jim and Elaine. A huge thank you to Jill Rolen, who taught me so much of how to push myself and to be disciplined; she showed me what I could become and gave me the lifelong gift of music. I also wish to thank Pastor Fred who exemplifies the actual Christian walk and without whom I do not believe I would be a Christian today. A huge thank you to Joy Turner who, along with Ron, provided unfailing love, support, and stability to me during my teenage years and beyond. Jami Sly for her patience and love. Lastly, I dedicate this to Dr. Don Van Ornam for showing me how to live and for giving me the freedom to be myself, and to my Uncle Byron; you are missed.

Table of Contents

List of Tables v

List of Figures vi

Chapter 1: Introduction to the Study 1

Background 2

Problem Statement 3

Purpose 4

Research Questions and Hypotheses 4

Theoretical Base 7

Nature of the Study 8

Definitions 8

Assumptions 10

Scope and Delimitations 10

Limitations 11

Significance 12

Summary 13

Chapter 2: Literature Review 15

Synopsis of Current Literature 15

Literature Research Strategy 17

Theoretical Foundation 18

Sexuality 21

Comfort 23

Health Care Professionals' Comfort With Sexual Topics 23
Counselors' and Therapists' Comfort With Sexual Topics 25
Psychologists' Comfort With Sexual Topics 28
Attitudes 29
Health Care Professionals' Attitudes Toward Sexual Topics 29
Counselors' and Therapists' Attitudes Concerning Sexual Topics 35
Psychologists' Attitudes Concerning Sexual Topics 38
Willingness to Engage 40
Health Care Professionals' Willingness to Engage Patients 40
Counselors' and Therapists' Willingness to Engage Patients 45
Psychologists' Willingness to Engage Patients 47
Knowledge 48
Health Care Professionals' Knowledge Regarding Sexual Topics 48
Counselors' and Therapists' Knowledge Regarding Sexual Topics 55
Psychologists' Knowledge Regarding Sexual Topics 57
Summary and Conclusions 59
Chapter 3: Methodology 61
Research Design and Rationale 62
Population 63
Sampling and Sampling Procedures 64
Procedures 65
Instrumentation and Operationalization of Constructs 66

Demographic Data 66
24-Item Miller-Fisk Sexual Knowledge Questionnaire 66
Sexual Comfort Scale 67
Brief Sexual Attitudes Scale 68
Sexuality Education Scale 69
Experience in Supervision Scale 69
Clinical Experience Scale 70
Sexuality Discussion With Clients Scale 70
Operationalization 70
Data Analysis Plan 72
Threats to External and Internal Validity 78
Threats to Statistical Validity 79
Normality 79
Homoscedasticity 80
Independence of Observations 80
Linearity 80
Multicollinearity 81
Outliers 81
Ethical Procedures 82
Summary 83
Research Questions and Hypothesis Testing 84
Data Collection 88

Description of Sample 89
Instrument Reliability for Sample 91
Descriptive Statistics 92
Research Question 1, Hypothesis 1 94
Research Question 2, Hypothesis 2 98
Research Question 3, Hypothesis 3 100
Research Question 4, Hypothesis 4 101
Research Question 5, Hypothesis 5 104
Research Question 6, Hypothesis 6 110
Conclusions 118
Chapter 5: Discussion, Conclusions, and Recommendations 120
Interpretation of the Findings 121
Limitations of the Study 126
Recommendations 127
Implications 128
Conclusion 130
References 132
Appendix A: Search Terms 154
Appendix B: Instrument Permissions 155

List of Tables

Table 1. Practice Setting 90

Table 2. Graduate Specialization *90*

Table 3. Reliability Coefficients for Sample *92*

Table 4. Descriptive Statistics *93*

Table 5. Skewness and Kurtosis Coefficients *94*

Table 6. Research Question 1 Correlation Results *95*

List of Figures

Figure 1. Graduate sexuality training and willingness to discuss sexual topics. 96

Figure 2. Supervision experience and willingness to discuss sexual topics 97

Figure 3. Clinical experience and willingness to discuss sexual topics. 98

Figure 4. Normal P-P plot for regression standardized residuals. 102

Figure 5. Scatterplot of standardized residuals by standardized predicted values. 103

Chapter 1: Introduction to the Study

Marriage and family therapists are uncomfortable discussing topics of a sexual nature (Cupit, 2010; Harris & Hays, 2008). Researchers have found that this lack of comfort has persisted (Dermer & Bachenberg, 2015). Beginning therapists are particularly prone to avoid sexual topics with their clients (Timm, 2009). Comfort impacts competency; knowledge alone is not sufficient (Dermer & Bachenberg, 2015). It is important to be both comfortable and knowledgeable as a therapist (Voss, 2015). The World Health Organization (2006) affirmed sexual health as a human right, and according to Dermer and Bachenberg (2015), therapists should affirm sexual health to their clients. However, adequate training to improve therapist comfort levels in sexual topics has not increased during the past 40 years (Dermer & Bachenberg, 2015). Attitudes and knowledge have an impact on how therapists practice therapy and how they implement interventions (Dermer & Bachenberg, 2015). Understanding therapists' attitudes toward sexuality will provide a better understanding of how attitudes impact the comfort level of the therapist when engaging the client on sexual topics (Dermer & Bachenberg, 2015; Russell, 2012).

In Chapter 1, I present an overview of this study, including a description of the social problem, gaps in the literature, and hypotheses. I introduce Bowen's (1976) theory, which provided the framework for the study. Finally, I define the terms and variables, present the research design, and discuss the limitations, delimitations, assumptions, and significance of the study.

Background

Harris and Hays's (2008) research on marriage and family therapists' willingness to engage in discussions of sexuality with their clients was the seminal work in this area and the only peer-reviewed journal article that addressed this variable within the Bowenian theoretical framework. Harris and Hays published their first study addressing marriage and family therapists' attitudes toward lesbian, gay, bisexual, and transgender (LGBT) individuals in 2012. There has been some research into the link between licensed clinical marriage and family therapists' (LCMFT) attitudes and comfort, and between LCMFTs' attitudes and practice (Anderson, 2002; Giami & Pacey, 2006; Juergens, 2006; Weerakoon & Stiernborg, 1996; Yelton & Delfin, 2015). There have been studies on the link between LCMFT knowledge, comfort, and attitudes toward sexuality (West et al., 2012). There have also been studies addressing how LCMFT comfort and knowledge impact willingness to discuss sexuality (Hanzlik & Gaubatz, 2012; Harris & Hays, 2008).

Only two studies addressed all four variables concerning how knowledge and attitudes about human sexuality impact comfort and willingness to engage with clients about their sexuality, but neither included participants from the marriage and family therapy community; instead, the authors surveyed counselors (Cupit, 2010; Juergens, 2006). Sexuality is important to the individual and is recognized not only for its importance but as a human right by the World Health Organization (2006). Therapists who do not address sexuality with their clients can cause harm both to themselves and the client (Cupit, 2010; LoFrisco, 2013; Ridley, 2006). Therapists are still "not comfortable discussing sexual issues with their clients" (Cupit, 2010, p. 9), and this is leading to harm

(Dermer & Bachenberg, 2015). There has not been a study addressing all of the variables as applied to marriage and family therapists. I intended for this study to fill the gap in the literature to increase the understanding of how personal attitudes about human sexuality factor into marriage and family therapists' willingness to discuss sexual topics with their clients. Findings may improve therapists' abilities to address this issue by reducing their anxiety and reducing the chance of harm to clients.

Problem Statement

The research problem was that marriage and family therapists are not comfortable discussing sexual issues with clients to the point of not being willing to broach the topic (Cupit, 2010; Dermer & Bachenberg, 2015; Harris & Hays, 2008; LoFrisco, 2013; Timm, 2009). Therapists may cause significant damage by not proactively addressing the issue of sexual health or by dismissing it when brought up by the client (Cupit, 2010; Harris & Hays, 2008; Juergens, Smedema, & Berven, 2009; LoFrisco, 2013; Papaharitou et al., 2008; Timm, 2009). Many therapists fail to assist their clients in dealing with these issues (Harris & Hays, 2008; Juergens et al., 2009; Papaharitou et al., 2008). Based on a literature search of many databases, I found only one peer-reviewed journal article that addressed marriage and family therapists discussing sexual issues with clients in which the researchers found a link between knowledge, comfort, and willingness to engage (Harris & Hays, 2008). I found only two peer-reviewed journal articles addressing the link between attitudes and comfort (Hanzlik & Gaubatz, 2012; Russell, 2012). Furthermore, I found only one peer-reviewed journal article addressing the variable of willingness to engage clients in sexual discussions with a marriage and family therapist

(Harris & Hays, 2008). If therapists do not help clients to feel comfortable talking about their sex life because they will not broach the topic of sexuality, then they should address this problem (Harris & Hays, 2008). Building upon the previous research by examining the variable of therapists' attitudes compared with the other three variables of knowledge, comfort, and willingness was needed to increase the knowledge base in the field (Cupit, 2010; Dermer & Bachenberg, 2015; Harris & Hays, 2008; LoFrisco, 2013; Miller & Byers, 2012; Russell, 2012).

Purpose

In this quantitative study, I used Bowenian theory to examine the relationship between therapists' attitudes, knowledge, comfort, and willingness to engage clients in a discussion of their sexuality (see Harris & Hays, 2008; Kerr & Bowen, 1988; Schnarch, 1998). The independent variables were (a) attitudes, (b) knowledge, (c) training, (d) supervision experience, (e) clinical experience, (f) sex, (g) age, (h) strength of religion, (i) sexual orientation, (j) practice experience, (k) practice setting, (l) graduate specialization, and (m) relationship status; the dependent variables were (a) comfort and (b) willingness to engage.

Research Questions and Hypotheses

The following research questions (RQs) and hypotheses were used to guide the study:

RQ1: What is the relationship between attitudes, knowledge, training, supervision experience, and clinical experience and a therapist's willingness to discuss sexual topics with clients?

$H_0$1: There is no statistically significant relationship between attitudes, knowledge, training, supervision experience, and clinical experience and a therapist's willingness to discuss sexual topics with clients.

H_a1: There is a statistically significant relationship between attitudes, knowledge, training, supervision experience, and clinical experience and a therapist's willingness to discuss sexual topics with clients.

RQ2: What is the relationship between attitudes, knowledge, training, supervision experience, and clinical experience and a therapist's comfort discussing sexual topics with clients?

$H_0$2: There is no statistically significant relationship between attitudes, knowledge, training, supervision experience, and clinical experience and a therapist's comfort discussing sexual topics with clients.

H_a2: There is a statistically significant relationship between attitudes, knowledge, training, supervision experience, and clinical experience and a therapist's comfort discussing sexual topics with clients.

RQ3: What independent variables (attitudes, knowledge, training, supervision experience, and clinical experience) predict a therapist's comfort level with sexuality?

$H_0$3: There is no statistically significant predictive relationship between the independent variables (attitudes, knowledge, training, supervision experience, and clinical experience) and a therapist's comfort level with sexuality.

H_a3: There is a statistically significant predictive relationship between the independent variables (attitudes, knowledge, training, supervision experience, and clinical experience) and a therapist's comfort level with sexuality.

RQ4: What independent variables (attitudes, knowledge, training, supervision experience, and clinical experience) predict a therapist's willingness to discuss sexual topics with clients?

$H_0$4: There is no statistically significant predictive relationship between the independent variables (attitudes, knowledge, training, supervision experience, and clinical experience) and a therapist's willingness to discuss sexual topics with clients.

H_a4: There is a statistically significant predictive relationship between the independent variables (attitudes, knowledge, training, supervision experience, and clinical experience) and a therapist's willingness to discuss sexual topics with clients.

RQ5: What is the relationship between the independent variables of a therapist's age, sex, sexual orientation, number of years in practice, type of graduate program, relationship status, practice setting, or strength of religion and the dependent variable of the sexual comfort of a therapist?

$H_0$5: There is no statistically significant relationship between the independent variables of a therapist's age, sex, sexual orientation, number of years in practice, type of graduate program, relationship status, practice setting, or strength of religion and the dependent variable of the sexual comfort of a therapist.

H_a5: There is a statistically significant relationship between the independent variables of a therapist's age, sex, sexual orientation, number of years in practice, type of

graduate program, relationship status, practice setting, or strength of religion and the dependent variable of the sexual comfort of a therapist.

RQ6: What is the relationship between the independent variables of a therapist's age, sex, sexual orientation, number of years in practice, type of graduate program, relationship status, practice setting, or strength of religion and the dependent variable of a therapist's willingness to discuss sexual topics?

$H_0$6: There is no statistically significant relationship between the independent variables of a therapist's age, sex, sexual orientation, number of years in practice, type of graduate program, relationship status, practice setting, or strength of religion and the dependent variable of a therapist's willingness to discuss sexual topics?

H_a6: There is a statistically significant relationship between the independent variables of a therapist's age, sex, sexual orientation, number of years in practice, type of graduate program, relationship status, practice setting, or strength of religion and the dependent variable of a therapist's willingness to discuss sexual topics.

Theoretical Base

The theoretical framework for this study was Bowenian theory (see Baer & Murdock, 1995; Bowen, 1976; Harris & Hays, 2008; Kerr & Bowen, 1988; Schnarch, 1998). Bowen (1976) developed this theory as a practicing therapist while observing families in both structured and unstructured settings. Bowen examined the ability of therapists to remain emotionally present and nonreactionary while being able to express their values and dispense assessments (Baer & Murdock, 1995). The major theoretical constructs of Bowenian theory appropriate for this study were therapists' anxiety and

reactivity (see Cupit, 2010; Harris & Hays, 2008). According to Bowenian theory, it is difficult for therapists to be helpful to clients in the therapeutic relationship when the therapists' emotional reactions interfere with their awareness (Kerr & Bowen, 1988; Schnarch, 1991). According to Harris and Hays (2008), "Bowen's concepts of anxiety and reactivity are helpful in conceptualizing why a therapist might not engage his or her clients in a discussion of sexuality" (p. 241). Basing this study on Bowenian theory may add to the understanding of how these variables fit into a system and impact therapists and how they may or may not relate to each other in decreasing anxiety (see Baer & Murdock, 1995; Harris & Hays, 2008). The goal of this study was to increase the understanding of how therapists may decrease their anxiety so they can positively engage the client in discussions of sexuality (Harris & Hays, 2008).

Nature of the Study

The nature of this study was quantitative. Previous studies had used quantitative methods based on Bowenian theory. I used a correlational study design to examine relationships among the variables.

Definitions

Attitudes (toward discussing sexuality with the client): Therapists' attitudes in this study were defined as therapists being aware of their biases, beliefs, and judgments and not allowing them to negatively influence their view of their clients as individuals or the subject matter broached by the client in the therapeutic relationship. A negative attitude toward a client's sexual orientation would constitute a barrier to the therapist's

effectiveness. Through self-understanding, negative attitudes can be avoided (Cort, Attenborough, & Watson, 2001; Masters & Johnson, 1970).

Comfort with sexual discussions: The therapist's ability to (a) accept and respect clients' sexual practices, (b) have open discussions about clients' sexuality, and (c) communicate effectively regarding sexuality (Graham & Smith, 1984). Comfort with discussing sexual issues is a broad concept involving "cognitive, affective, and behavioral responses to sexuality" (Graham & Smith, 1984, p. 439). The ability to be comfortable with sexual issues is "a developmental task influenced by the physiological, psychological, sociological, spiritual or religious, educational, and sexual aspects of one's being." (Graham & Smith, 1984, p. 440).

Sexual issues: Sexual issues and dysfunctions "are broadly defined as any sexual concern a client may have and the psychological issues that accompany it" (LoFrisco, 2013, p. 17). Examples of common sexual issues include "sexual performance, sexual dysfunctions, gender issues, sexual abuse, sexual disorders, sexual addiction, sexual trauma, sexual shame and sexual intimacy issues" (LoFrisco, 2013, p. 17).

Sexual knowledge: "Sexual knowledge is defined as possession of correct information regarding human sexuality, including a good understanding of the dynamics and psychological effects of sexual dysfunctions, information about the sexual response phases, and an awareness of what is considered to be normal or average" (LoFrisco, 2013, p. 17).

Willingness (to engage a client in a discussion about sexuality): The likelihood that the therapist will proactively broach or discuss sexual issues with the client (Harris & Hays, 2008).

Assumptions

I made several assumptions in this quantitative correlational study. I assumed that therapists want to help their clients. I also assumed that therapists who filled out their surveys were honest and that the information provided by them was accurate. I assumed that the therapists who filled out the survey were representative of the larger population. I assumed, as did Cupit (2010), that "the instruments that were used in this study are reliable and valid and accurately measure sexual comfort [and therapists'] sexual attitudes, sexual knowledge, training experience with sexual issues, supervision experience addressing sexuality, and clinical experience with sexual issues" (p. 14). I assumed that the participants volunteered willingly and that their answers did not reflect any impairment or agenda or were given while under duress. Because the participants answered questions anonymously, I assumed that the participants were licensed marriage and family therapists and that they fully understood the informed consent packet and how anonymity and confidentiality worked as it pertained to the survey. These assumptions were necessary to meet the demands of social science research standards as laid out by Creswell (2013).

Scope and Delimitations

I limited the study to licensed marriage and family therapists practicing in the United States. The study focused on the quantitative gaps in the research regarding how

therapists' knowledge and attitudes impact comfort and willingness to engage clients. The study included an online survey made up of seven scales to assess these variables and their potential correlations. Therapists answered questions regarding their knowledge of sexual issues/sexuality, attitudes toward sexual issues/sexuality, training, education, clinical experience, and supervision experience. Additionally, therapists answered questions regarding their comfort while discussing sexual issues with clients and their willingness to initiate the discussion with a client regarding sexual issues. I tested the hypotheses using a quantitative correlational research design (see Bramante, 2015), and research questions to determine whether there were any relationships between the independent variables and dependent variables. Generalizability of this study was limited because I only drew participants from the United States; the theoretical perspective of Bowen can also be viewed as a delimitation. Also, I did not include sexual inappropriateness, sexual transference, and sexual counter-transference in this study, nor did I include criteria regarding sexual orientation because they were beyond the scope of this study.

Limitations

Pyrczak and Bruce (2000) defined a limitation as a "weakness or handicap that potentially limits the validity of the results" (p. 57). In this study, there were limitations related to internal validity, including methods of sampling, instrumentation, testing, and administration. Even with a random sample, the level of control is reduced because of the design being quasi-experimental and not purely experimental (see Campbell & Stanley, 1966). Regarding testing and survey administration, this study was not on par with any

study that included in-person methods to collect data, and because the study was web based, nonresponses may have increased due to lack of access or inability to understand how the survey link and Survey Monkey system works (see Millar & Dillman, 2011). Internet surveys are affordable and efficient and allow a broad reach that might not otherwise be possible, which made them a good fit for this study despite the limitations (see Ward, Clark, Zabriskie, & Morris, 2012). Additional limitations of this study were that therapists may have felt they must provide the politically correct or socially enlightened answer that did not reflect their true perspective. Also, a more conservative or traditional therapist may have avoided answering certain survey questions because of their potential for being too personal in nature; this may have also led therapists to not return the survey or to exit the survey early because they did not want the information to be known even though I assured them anonymity.

Significance

Therapists need to be willing to initiate and discuss with clients, their sexual health issues (LoFrisco, 2013). Because this is not occurring on a regular basis, I conducted a study to address how the therapy community may increase the willingness of therapists to discuss sexual issues with their clients. Anderson (2002) asked "what effect does the combination of the variables of human sexuality knowledge, experience, and attitudes have on the sexual comfort" (p. 8) and willingness to engage clients in discussions of sexuality? I attempted to answer this question to further the understanding in this area. Few researchers have delved into this area, and this gap in understanding negatively impacts millions of Americans who rely on marriage and family therapists for

guidance when dealing with sexual health issues (Cupit, 2010; Dermer & Bachenberg, 2015; Harris & Hays, 2008; Juergens et al., 2009; LoFrisco, 2013; Papaharitou et al., 2008; Timm, 2009). The results of this study may inform the marriage and family therapy community education curriculum used to prepare therapists in school and postgraduate studies, and the results of this study may inform the training methods used in workshops, supervision, and clinical settings to prepare therapists through understanding of the elements that impact their willingness to discuss sexual health issues with a client (see Cupit, 2010). Therapists may use the results from this study as a basis for positive change within the marriage and family therapy community by addressing a problem and suggesting potential solutions so that the population that is suffering from sexual dysfunction may be better served.

Summary

Chapter 1 provided an overview of the scope of this study concerning marriage and family therapists and the pressing concern that therapists are not initiating and engaging in discussions with their clients regarding sexual health issues. The potential for harm to the client formed part of the basis for this study; the other was the dearth of literature in this area. I reviewed the independent variables addressed in this study (knowledge, with its subsets of training, supervision, clinical experience, and attitudes) and the dependent variables of comfort and willingness to engage and discuss with a client regarding a sexual issue. I described the quantitative correlational research design, including the survey method. The survey comprised instruments that were reliable and valid, and I analyzed data using multiple regression analysis. The results from this study

may be used to start a conversation within the marriage and family therapy community in hopes that educational institutions will take note and better prepare marriage and family therapists for practice. Findings may also be used to improve the care provided by those in practice. In Chapter 2, I review the literature from other disciplines in addition to the marriage and family therapy discipline to provide an in-depth perspective on the issues.

Chapter 2: Literature Review

A current problem within the community of marriage and family therapists is a lack of knowledge, comfort, and willingness to engage clients about their sexuality (Dermer & Bachenberg, 2015; Harris & Hays, 2008). Therapists are not engaging their clients regarding sexual health issues because of lack of comfort; avoiding or dismissing the issue can result in damage to the client (Cupit, 2010; Harris & Hays, 2008; Juergens et al., 2009; LoFrisco, 2013; Papaharitou et al., 2008; Timm, 2009). The purpose of this study was to examine the relationship between the independent variables of therapists' attitudes and knowledge and the dependent variables of therapists' comfort with sexual topics and willingness to discuss sexual topics. A better understanding of how these variables interact with each other during the process of therapeutic discussions of sexuality from the therapists' perspective may provide a significant addition to the body of research in this area.

Synopsis of Current Literature

Haesler, Bauer, and Fetherstonhaugh (2016) studied health care professionals' attitudes and knowledge regarding sexuality and found a lack of confidence and knowledge in providing treatment to patients; many health care professionals in their study considered sexuality to be outside the scope of their practice, while still indicating "that a positive and respectful attitude toward sexuality is important" (as cited in Saunamäki, Andersson, & Engström, 2010, p. 1308). Haesler et al. (2016) found that therapists' knowledge and attitudes were significant contributors to predicting how therapists interacted with clients regarding sexuality. Although health care professionals

as a group considered sexuality to be an important part of the human experience, many did not wish to provide treatment in that area for their clients (Verschuren, Enzlin, Geertzen, Dijkstra, & Dekker, 2013). According to Cupit (2010), there has been a steady decline in research in the area of sexuality since the 1970s. Dermer and Bachenberg (2015) found that marriage and family therapists have not made any significant progress in the past 40 years, and that their comfort has not improved regarding sexuality as a topic. Russell (2012) examined counselors' attitudes and knowledge about sexuality as a topic and found that attitude was the primary predictor of whether counselors addressed sexuality with clients. The first researchers to address therapists' comfort and willingness to engage in topics of sexuality were Harris and Hays (2008). Since then, several other researchers have examined different groups—primarily counselors and psychologists—about several relevant variables, but no study has addressed all four variables as applied to the marriage and family therapist community. Given the importance of human sexuality to the individual, the prevalence of sexual dysfunction presently occurring in both men and women, and the therapeutic setting offering the only available resource for individuals, broadening the understanding of this issue is important to encourage more effective practice among marriage and family therapists (Bancroft, 2009a; Harris & Hays, 2008; Laumann et al., 2007; Lyons, Bieschke, Dendy, Worthington, & Georgemiller, 2010; Shifren, Brigitta, Russo, Segreti, & Johannes, 2008).

Chapter 2 starts with a discussion of the research strategy employed in compiling this literature review, along with key terms used and databases accessed. I discuss the theoretical foundation upon which I based this study—Bowen's theory (see Kerr &

Bowen, 1988). Bowen posited that anxiety held therapists back from discussing sexual topics with clients (Harris & Hays, 2008; Kerr & Bowen, 1988). Following the presentation of the theoretical foundation, I discuss each variable (knowledge, attitude, comfort, and willingness to engage) within several subsections of health care professionals, including counselors, therapists, and psychologists. I explain the importance of these variables to therapeutic practice, their relevance to this study, the gap in the literature, and the need for further study. I conclude with a summary.

Literature Research Strategy

I conducted multiple searches using the following databases: Academic Search Complete, Dissertations and Theses, Dissertations and Theses at Walden University, ERIC, Expanded Academic ASAP, MEDLINE (with full text), ProQuest Central, ProQuest Health & Medical Complete, ProQuest Nursing & Allied Health Source, PsycARTICLES, PsycINFO, PubMed, SAGE Premier, SocINDEX (with full text), Taylor and Francis Online, and Thoreau Multi-Database Search. I also used the Google Scholar search engine. The key words used in the literature review included *counselor, therapist, psychology, psychologist, therapy, marriage* and *family therapy/therapist, nurse, nursing, medical, health care, allied health, health care professional,* and *physician*. I combined these search terms with the words *sex, sexuality, attitude, comfort, knowledge, approach, willingness to engage,* and *discussion*. For example, one search included the words "therapist attitude sexuality." Appendix A provides a detailed list of search terms.

I used the same databases to search for Bowen's theory related to sexuality in a therapeutic context. Most authors published their materials within the last 5 years. Although this filter was typically viable in the area of medicine and health care, other areas lacked relevant literature within the 5-year parameter. Peer-reviewed journal articles constitute most of the literature cited in this chapter. I also review doctoral dissertations, textbooks, and handbooks.

Because the focus of this study was sexuality and how it is addressed in a therapeutic setting, sex, sexuality, and sexual issues are thoroughly defined and reviewed. I included all available research in the area of marriage and family therapists' comfort, knowledge, attitudes, and willingness to discuss sexual issues with clients. In the area of marriage and family therapy, the seminal work was Harris and Hays's (2008) study regarding therapists' comfort and willingness; this was the only peer-reviewed research related to this area as applied specifically to marriage and family therapists. Miller and Byers (2012) conducted important research regarding psychologists, a different type of mental health professional. Similar to Cupit (2010), I found limited literature available on these subjects, so I expanded my review beyond the marriage and family therapy area to include other health care professionals such as counselors, psychologists, and rehabilitation counselors, which proved helpful and illustrative of the issues facing the marriage and family therapy community.

Theoretical Foundation

Bowen (1976) developed a family systems theory based on his work as a practicing family therapist, observing clients in both structured and unstructured settings.

The major theoretical constructs of Bowenian theory appropriate for this study were anxiety and reactivity (see Cupit, 2010; Harris & Hays, 2008, Schnarch, 1998). When therapists' emotional reactions interfere with their awareness, it is difficult to be helpful in the therapeutic relationship (Kerr & Bowen, 1988; Schnarch, 1991). Schnarch (1991) emphasized how important human sexuality was by stating that "the expression of sexuality is a window into who each person is and how they relate to each other" (p. 20). If therapists lose awareness of what is going on within the therapeutic relationship because they have become anxious and allowed their emotions to stop or severely impede the process, they not only impair the process with clients but "also could perpetuate the symptoms of the problem within the system" (Harris & Hays, 2008, p. 241). This lack of awareness causes the exact type of harm that Cupit (2010) and LoFrisco (2013) stated should not occur in the therapeutic relationship. The way that therapists have dealt with this anxiety is by not addressing the topic (Cupit, 2010; Harris & Hays, 2008; LoFrisco, 2013; Schnarch, 1991; Yelton & Delfin, 2015). It is imperative that the therapist is relaxed when initiating the discussion about sexuality, and the therapist needs to be aware that the client is often waiting for the therapist to initiate the discussion (Harris & Hays, 2008; Hays, 2002). For an individual to become a fully integrated sexual being, the therapist must act as the model of how to move past the anxiety that is acting as a barrier to progress (Harris & Hays, 2008; Schnarch, 1991, 1998). Harris and Hays (2008) applied Bowen's theory in their research, which addressed the relationships "between therapists' sexual knowledge and their comfort with sexual material and how these

factors influenced the likelihood that the therapists will engage in sexual discussions with their clients" (p. 241).

Cupit (2010) chose Rogers's (1951) person-centered theory of self-actualization as the lens through which to analyze the subject of counselors' comfort and willingness to discuss sexual topics with clients. Cupit also used four of the instruments developed by Harris and Hays (2008) in her study design. Cupit and LoFrisco (2013) both cited the lack of research that continues to negatively impact this area, a circumstance that led Cupit (2010) to use the Harris and Hays (2008) instruments.

I chose the Bowenian theory for the current study to further Harris and Hays's (2008) seminal research and to stay within the framework they established on this topic. I also chose Bowenian theory to address the main issues reported by therapists in discussing sexuality with clients: that they feel anxious, emotionally unready, and reactive about starting a discussion about a client's sexual health. Kelsey, Stiles, Spiller, and Diekhoff (2013) found that 52% of therapists do not view themselves as competent to discuss bondage, dominance, sadism, and masochism with clients and would refer a client presenting with this issue to someone else.

The Bowenian theory was appropriate for the present study because it was the only theory chosen by Harris and Hays (2008). Moreover, there had not been any research done in this area since the Harris and Hays study. The Bowenian theory provided the best lens to understand anxiety and emotional reactivity on the part of the therapist when discussing sexual topics with clients. Also, Bowenian theory provided continuity to the reader by building on the framework developed by Harris and Hays

(2008). The research questions related to Bowenian theory focused on the influence the perceptions of sexual knowledge have on therapists and how to increase their feelings of competency. I included attitude as the missing variable to provide a clearer picture of what factors influence therapists in their willingness to engage clients in a discussion about sexuality.

Sexuality

Sexuality is an important aspect of people's lives and a major component of mental health for the client (Bancroft, 2009a; Cupit, 2009; Lyons et al., 2010). Human sexuality "encompasses gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction" (WHO, 2006, p. 5). Diamond and Huebner (2012) supported the links between well-being and sexuality and between the quality of life and sex life of a couple. An individual's sexuality is a human right that the therapist should cherish and nurture. However, the ideological background of the therapist can inhibit open discussion (M. S. Green, Murphy, & Blumer, 2010).

Shifren et al. (2008) found that 43% of adult women suffered from ongoing, regularly recurring sexual dysfunction. This rate varied depending upon which dysfunction was being measured (arousal, interest, lubrication, or failure to orgasm) ,but the incidence at which these dysfunctions occurred appeared to support previous research (McCabe et al., 2016). Because of the small amount of literature on this topic, however, it was difficult to assess the scope of female sexual dysfunction in the United States (McCabe et al., 2016).

Men were also likely to have sexual dysfunction issues, with 22% over age 40 suffering from erectile dysfunction (Laumann et al., 2007). If a sexual issue remained unresolved, the potential consequences were less happiness for the individual, which then impacted his or her well-being (Rosen & Bachmann, 2008). Despite the regularity with which sexual issues occur and the negative consequences if sexual issues are not addressed, there exists a systemic failure by the therapeutic community to address these concerns (Harris & Hays, 2008; Juergens et al., 2009; Papaharitou et al., 2008; Weerakoon, Sitharthan, & Skowronski, 2008). Cupit (2010) noted the steady decrease of research on the topic of sexuality since the 1970s.

In the *Diagnostic and Statistical Manual of Mental Disorders* (DSM–5; American Psychiatric Association, 2013), the authors have reorganized sexual disorders, and they have merged or eliminated some categories entirely (Graham, 2016). For example, the authors combined hypoactive sexual desire disorder and female sexual arousal disorder into a single, broader definition: female sexual interest/arousal disorder (Graham, 2016). In the same fashion, they merged dyspareunia and vaginismus into genito-pelvic pain/penetration disorder (IsHak & Tobia, 2013).

Male hypoactive sexual desire disorder is now a category. The authors renamed male orgasmic disorder as delayed ejaculation with broader definitions included and both male dyspareunia and male sexual pain were removed (IsHak & Tobia, 2013). The authors did not make these changes without controversy but reflected the most current empirical research available (IsHak & Tobia, 2013). That the DSM-5 includes these

sexual disorders and syndromes and that the definition of specific disorders is still in flux indicates the ongoing importance of human sexuality as related to psychotherapy.

Comfort

Health Care Professionals' Comfort With Sexual Topics

Graham and Smith (1984) developed the following definition of sexual comfort over 30 years ago: "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" (p. 439). This definition continues to provide a framework to determine the comfort level of therapists dealing with the topic of sexuality with clients. Graham and Smith (1984) found that attitudes, feelings, and communication skills had an impact on sexual comfort. Haboubi and Lincoln (2003), in their survey of 100 doctors, nurses, occupational therapists, and physiotherapists found that 90% of respondents agreed that sexual health was important and that they should address it as part of the health care approach. Ninety-four percent of these health care professionals would not initiate a discussion of sexuality with a patient due to lack of comfort. Most felt poorly trained to handle a discussion regarding a patient's sexuality (Haboubi & Lincoln, 2003). These findings were similar to previous research, however, about whether gender, attitude, or knowledge impacted this discomfort. Fifty percent of the respondents cited embarrassment as a barrier to discussing sexual issues, even though 60% of respondents said that they would feel comfortable discussing sexual issues with clients (Haboubi & Lincoln, 2003). In a more recent study of nurses, researchers found

that 66% felt comfortable discussing sexual issues with patients (Saunamäki et al., 2010). Older nurses were more confident and comfortable discussing patients' sexual issues and concerns and also displayed a more positive attitude toward sexuality and dealing with sexual health. In a similar study, 67% of nurses felt comfortable discussing sexual issues with patients, but only 40% felt the need to do so; 33% did not feel comfortable initiating the discussion or discussing sexual health issues with patients (Kotronoulas, Papadopoulou, & Patiraki, 2009). In an earlier study, Magnan and Reynolds (2006) found that OB/GYN and rehabilitation nurses were more comfortable than their other nursing specialization peers and noted certain specializations as a barrier to discussing sexual issues with patients.

Lack of comfort and failure to address sexual issues was also found in surveys involving physicians, but was more pronounced in geriatric care, female-specific care, and disabilities (Haboubi & Lincoln, 2003; Maciel & Laganà, 2014; Pauls et al., 2005; Thomason, Capps, Lefler, & Richard-Davis, 2015). In a qualitative study of physicians from the United Kingdom, Dyer and das Nair (2013) found that physicians were not comfortable initiating conversation with patients regarding sexual issues due to personal discomfort and a fear of "opening up a can of worms" (p. 2658). Physicians also noted a greater challenge when addressing sexuality with minority groups, including Blacks, nonheterosexuals, people with disabilities, and the aging (Dyer & das Nair, 2013). Verschuren et al. (2013) found that 67% of the 177 health care professionals surveyed had not addressed sexuality with patients. The authors discovered this particular group of physicians and rehabilitation professionals ranked high on the comfort index; however,

the majority did not consider it their role to discuss sexual issues with patients being fitted for prosthetics.

Kazukauskas and Lam (2010) found that comfort was at a medium level for rehabilitation health care professionals. They also found a correlational link between attitudes and knowledge impacting the comfort of the rehabilitation health care professional when approaching and discussing sexual topics with patients.

Helland, Garratt, Kjeken, Kvien, and Dagfinrud (2013) found that Rheumatology physicians who had sexuality-specific education were more comfortable discussing the associated topics with patients. Higgins et al. (2012) found that when health care professionals engaged in a one-day program geared toward an interdisciplinary approach to sexuality, participant comfort levels regarding sexuality increased. In a longitudinal mixed methods study of 37 rehabilitation practitioners that comprised of 23 nurses, ten community staff, three allied health and one medical practitioner, researchers found that comfort did not change significantly over time between the control and experimental group. Nevertheless, comfort did increase over a 2-year period (although the authors did not proffer an opinion about why) (Fronek, Kendall, Booth, Eugarde, & Geraghty, 2011).

Counselors' and Therapists' Comfort With Sexual Topics

Sexual comfort impacts every aspect of the client's being and the comfort level of counselors and therapists in discussing sexuality with their clients should be of prime importance (Graham & Smith, 1984). As the counselors' knowledge of sexuality increase, their comfort levels increase as well (Graham & Smith, 1984). Haboubi and

Lincoln (2003) found that doctors and nurses were more comfortable discussing sexual topics with patients than therapists were with their clients.

If clients felt that their therapists were not comfortable with the topic of sexuality, that discomfort could damage the therapeutic relationship, make the topic taboo, or alienate clients from the help they need (Cupit, 2010). In a study of counselors, Anderson (2002) analyzed the variables that impact comfort and found a positive correlation between experience and comfort: The more years in practice correlated with greater comfort in discussing sexual topics. However, the largest predictor variable of comfort was the counselor's attitude toward sexuality; therapist instructors were encouraged to promote more liberal sexual attitudes among their student therapists (Anderson, 2002).

In research involving mental health counselors, participants reported being comfortable with sexual topics, but that did not correlate with how frequently they initiated those topics with clients (LoFrisco, 2013). The research also reported that counselors who often initiated sexual conversations with clients also had a higher level of comfort with sexuality.

Sexuality is a sensitive topic and several researchers have determined that therapists' and counselors' levels of comfort in discussing sexual topics with clients need to increase so that they can address clients' sexual concerns (Harris & Hays, 2008; Hartl et al., 2007; Papaharitou et al., 2008; Weerakoon et al., 2008). Counselors prepare to initiate sexual discussion and normalize it because they cannot assume that "…clients will initiate a discussion about sexual health issues even when it is an area of concern for them" (Hays, 2002, p. 4).

LoFrisco (2013) pointed out that there is little empirical research on how the willingness component of the process can increase. Furthermore, the research done to date to find a connection between knowledge and comfort has been conflicting. Harris and Hays (2008) did not find a connection, nor did Decker (2010), which corroborates previous findings by Ford and Hendrick (2003). However, Haag (2008) and Weerakoon et al. (2008) did, in fact, find a positive correlation between knowledge and comfort in direct contradiction to the other researchers.

Harris and Hays's (2008) study was the only one exploring the relationship between comfort and knowledge and how these impact therapists' willingness. However, they did not measure test–retest reliability or content validity and used low-reliability portions of their instrument. Haag (2008) used no reliability or validity measures.

Comfort is not just an aspect of how the therapist and counselor view the topic of sexuality, but also impacts how the counselor addresses an individual belonging to a sexual minority (M. S. Green et al., 2010). Student counselors were uncomfortable when addressing issues with lesbian and transgender couples (Rutter, Leech, Anderson, & Saunders, 2010). Therapists who support civil unions and human rights are more comfortable discussing sexual topics with gay, lesbian, bisexual, and transgender (LGBT) individuals, but less comfortable when discussing sexual topics with couples (M. S. Green et al., 2010). This result was supported by the research of Juergens et al. (2009) and M. S. Green et al. (2010), who found that therapists' attitudes impacted comfort. Kazukauskas and Lam (2010) found that knowledge and attitude were significantly correlated with comfort on the part of the counselor engaging the patient to discuss a

topic regarding sexuality. In a more recent study, Pebdani (2013) tried to determine what correlations could be established regarding rehabilitation counselors and found that knowledge had a negative correlation to discomfort. As sexual knowledge increased, discomfort levels decreased.

Pukall (2009) argued that the therapist who was not comfortable discussing sexual health issues could not provide effective therapy. Therapists' or counselors' discomfort in discussing sexual topics was a significant barrier in the ability of clients to establish a therapeutic alliance with them and receive quality care (Bancroft, 2009b; Kazukauskas & Lam, 2010; Moser, 2009; Nasserzadeh, 2009). Donovan (2011) and Cupit (2010) both found that proper supervision and training helped to increase comfort for the therapist or counselor, and thereby, diminished this barrier.

Voss (2015) found that comfort for therapists and counselors who dealt with sexual topics impacted competencies. Therefore, comfort was an important facet of therapists' relationships with clients. Easton's (2015) research involving rehabilitation counselors working with patients with autism found they were more comfortable when addressing general sexual issues than when addressing sexually-explicit topics (such as masturbation). For the community of marriage and family therapists and counselors as a whole, there has been little overall improvement in comfort regarding discussion of sexuality over the past 30 years (Dermer & Bachenberg, 2015).

Psychologists' Comfort With Sexual Topics

Clinical psychology students were the participants in three studies regarding sexuality and comfort (Hanzlik & Gaubatz, 2012; Miller & Byers, 2012; Zimmerman,

2015). Hanzlik and Gaubatz (2012) did a cross-sectional study of 138 clinical PsyD students to assess their comfort levels when dealing with clients' sexual issues. Hanzlik and Gaubatz found that trainees had lower levels of comfort when discussing specific sexual concerns but had higher levels of comfort "when asked globally about discussing sexual issues with clients" (p. 219). These researchers also found that trainees had similar levels of comfort in discussions of sexuality with female clients, but female trainees had lower levels of comfort compared to their male peers when discussing sexual issues with male clients. Hanzlik and Gaubatz found a positive correlation between sexual attitudes and comfort and between sexual training and comfort but did not find any correlations between general education and comfort.

Zimmerman (2015) found that 85.1% of the clinical psychology student participants in their study were comfortable with transgender clients but had insufficient training to help implement action for these clients. Miller and Byers's (2012) study design included psychologists and their findings indicated that with sexuality-specific education and supervision, participants' confidence and self-efficacy—variables related to comfort—increased.

Attitudes

Health Care Professionals' Attitudes Toward Sexual Topics

Sexuality and sexual health are a priority in the treatment of patients (Cupit, 2010; Helland et al., 2013; Verschuren et al., 2013). Verschuren et al. (2013) found that two-thirds of physician participants in their research thought sexuality was important, but only one-third considered it part of their duties to engage the patient in sexual topics. These

researchers coined the term *conspiracy of silence* to indicate a dynamic in which both the physician and the patient avoid potentially awkward discussions about sexuality (Verschuren et al., 2013). Similarly, Helland et al. (2013) found that 96% of health care providers involved in rheumatological care considered sexuality to be a relevant topic, but 71% of these participants rarely or never raised the issue while 88% thought the patient should initiate this topic.

In the past decade, there has been a positive shift in the attitudes of health care workers regarding sexuality and the treatment of individuals who are members of the LGBT community (McCune, Imborek, Ho, Hardy-Fairbanks, & Stockdale, 2015). For my purpose, "the definition of attitude involves an emotional expression of what we value, believe in, and what we consider to be 'right'" (see Stuart, 2014, p. 23).

Nicol, Chapman, Watkins, Young, and Shields (2013) had similar results. Attitudes of health care professionals were significantly impacted by "…professional group, gender, Caucasian race, political voting behavior, presence of religious beliefs, the frequency of attendance at religious services, the frequency of praying, and having a friend who was openly lesbian, gay, bisexual and transgender" (p. 3396). Wilson et al. (2014) found that religiosity and familiarity with sexual issues and LGBT issues were predictive of less positive attitudes toward sexuality, treatment of sexual health issues, and dealing with LGBT patients with the 475 mental health students who participated in their survey.

Universally positive and open-minded attitudes toward sexuality were not the norm, however. For example, Malaysian medical student participants held conservative

beliefs and did not wish to engage with patients on various sexual health topics (Sidi et al., 2013). A recent study of Brazilian OB/GYN medical students revealed conservative attitudes as well (Vieira et al., 2015).

Turkish nurse participants held conservative, negative attitudes toward sexuality and discussing sexual issues with patients (Arikan, Meydanlioglu, Ozcan, & Ozer, 2015). However, Bal and Sahiner (2015), who conducted a similar study of 155 Turkish nurses in the same year, found these negative and conservative attitudes could improve with proper, sexuality-specific training. In contrast, male medical students in India held neutral attitudes toward homosexual patients, homosexuality, and discussing sexual topics with non-heterosexual patients while female medical students held positive attitudes (Banwari, Mistry, Soni, Parikh, & Ghandi, 2015). These researchers noted a lack of sexual knowledge among participants, which they attributed to underlying attitudes; other research echoed this analysis (Banwari et al., 2015; Sidi et al., 2013).

Studies focused on nurses' attitudes have been evenly split. For example, in their research with nurses, Kotronoules et al. (2009) found that participants had positive attitudes toward sexuality. In contrast, others found negative attitudes among their nursing participants toward sexuality and dealing with sexual health issues (Chapman, Watkins, Zappia, Nicol, & Shields, 2012; Eliason, DeJoseph, Dibble, Deevey, & Chinn, 2011). Based on the data collected from nursing students, Strong and Folse (2015) found negative attitudes when participants discussed sexuality with patients in the LGBT community. Attitudes improved significantly, however, after an intervention was administered to these student nurses (Strong & Folse, 2015). Likewise, Tugut and

Golbasi's (2015) research noted this effect in nurses when attitudes, knowledge, and behaviors improved after receiving specific sexuality assessment skills training. Sung and Lin (2013) found among their nurse participants in a quasi-experimental study with a control group that sexuality-specific training positively affected attitudes, beliefs, and behaviors. Sung, Huang, and Lin (2015) found a relationship between knowledge and attitude and the importance of not only educating nurses with sexually specific training to improve knowledge, but also to stress the importance of a positive attitude toward sexual health issues when dealing with patients.

Lapinski, Sexton, and Baker (2014) found that osteopathic medical students had positive attitudes toward sexual minority patients when discussing sexual issues and treating them; participants who self-identified as LGBT had even higher positive scores in the attitude category regarding discussion and treatment. However, these osteopathic students were unequipped to treat the LGBT population; the researchers recommended LGBT sexuality-focused education to remedy this deficit among this category of health care practitioners (Lapinski et al., 2014).

The data from nonwestern, non-North American midwives showed participants to have positive attitudes toward sexuality, discussing sexual topics with patients, and providing counseling on sexual topics. However, this was a single study, and the data may not be generalizable to the field of midwifery (Khadivzadeh, Ardaghi, Mazloum, & Modaresi, 2016). These participant midwives were also inadequately trained and had a significant lack of sexual knowledge (Khadivzadeh et al., 2016).

Valvano et al. (2014) found a general difference among 479 members of various health care disciplines regarding educational quality and quantity. There was also a wide variation of attitudes with dentists having the most negative. Based on their research, 34% of medical students and 98% of psychology students had no patient contact regarding sexual health issues. Valvano et al. (2014) stressed that negative attitudes could have an undesirable impact on patients, while attitudes toward sexual health issues among health care professionals seemed to be positive; these attitudes linked to sexually-specific health training. They argued that it was important to provide this type of training (Valvano et al., 2014).

Physician's assistants had liberal attitudes toward sexuality, with the majority (64%) holding these liberal attitudes, 35.4% holding neutral attitudes, and 0.6% holding conservative attitudes (Wolf, 2012). Two factors significantly impacted the physician's assistants' attitudes: ethnicity and relationship with religion. Wolf (2012) urged students to examine their sexual beliefs and attitudes due to the impact those beliefs and attitudes would have on their ability to assist patients with their sexual health issues. Wolf's (2012) question on religion was a simple "yes" or "no" question as to whether the participant considered themselves to be religious. In contrast to Wolf's findings, Cupit (2010), in her study of counselors, did not find any statistically significant relationships between her independent variables and religion. I did not find any other studies in my literature review that included the variable of religion. Harris and Hays (2008) suggested that religion was a variable that should be included in future research, which is why Cupit (2010) included it as a single item on a Likert-type scale of 1 to 5 in her research.

Health care professionals' attitudes toward the sexuality of their older patients were markedly different between people working in nursing home medical facilities and those working in hospitals (Doll, 2013). Thirty-two percent of the nursing home administrators and nurses reported that they would be disgusted to discuss sexuality with a patient, while 20% stated that they would panic, and "20% would ignore the behavior" (Doll, 2013, p. 59).

Haesler et al. (2016) conducted a systematic review of 23 studies concerning health care professionals' knowledge and "attitudes toward sexuality and sexual health of older people" (p. 65) that they published during an 11-year period (2004 to 2015). The authors concluded that practitioners were still reluctant to engage older patients on their sexuality due to attitudes influenced by negative and less permissive societal attitudes and lack of knowledge.

Moreno, Gan, Zasler, and McKerral (2015) found that physicians treating traumatic brain injuries thought that sexuality was important and had positive attitudes toward discussing it. However, they did not discuss sexuality with patients. The physicians who treated traumatic brain injuries had more positive and permissive attitudes than other participants who included family care physicians, psychologists, general practitioners, and other highly educated health care professionals (Moreno et al., 2015).

These various researchers who had focused on the attitudes of health care professionals regarding sexuality and discussing sexual topics with their patients had

reached different conclusions. Results were influenced by the area, specialty or discipline in question, geographic region, and cultural background of participants.

Counselors' and Therapists' Attitudes Concerning Sexual Topics

Attitudes are concepts that therapists apply to social objects that have a firm base. Conversely, the values held by therapists tend to focus more on ideals (Hitlin & Piliavin, 2004). Several researchers have concluded that therapists avoid sexual discussions due to lack of comfort (Harris & Hays, 2008; Shalev & Yerushalmi, 2009; Timm, 2009). It is assumed that greater knowledge would equate to greater comfort. However, attitude is another important component of the process that can lead to comfort and willingness to discuss sexual health issues (Papaharitou et al., 2008). Personal values and experiences influence attitudes toward sexual issues; through training and self-awareness, comfort can increase, anxiety can decrease, and willingness to engage can begin (Hilton, 1997). While authors conducted a number of studies in the late 1990s and early 2000s (as reviewed in the following paragraphs), a lack of new literature exists on attitudes, knowledge, practices, and behaviors concerning engaging clients in sexuality discussions among marriage and family therapists and counselors (Dunk, 2007; Yelton & Delfin, 2015).

In her research of 310 licensed counselors in three different states, Anderson concluded that a "combination of factors influenced counselors' sexual comfort and willingness to engage clients about sexual health issues " (as cited in Cupit, 2010, p. 23). Most impactful were sexual attitudes, training and experience, and personal experience. Harris and Hays (2008) addressed several of these components and determined that supervised experience and training, along with knowledge, improved sexual comfort.

Juergens (2006) found that sexuality education and knowledge impacted attitudes and attitudes impacted comfort. Cort et al. (2001) identified negative attitudes as a major barrier that prevented the discussion of sexuality with clients. Hilton (1997) found that counselors' comfort was linked to their attitudes about sexuality and their knowledge-base about sexuality. Similarly, Weerakoon and Stiernborg (1996) found a positive relationship between sexual attitudes and knowledge. This, in turn, influenced sexual comfort.

If the therapist's perception of the patient's sexual attitudes and values appeared to be of a nontraditional making, the therapists were less likely to engage the clients in sexual discussions (Weerakoon & Stiernborg, 1996). Negative bias in this area was why it was important for therapists to understand their attitudes regarding sex and sexuality (Stayton, 1998). As therapists increased their awareness, it became more likely they would also decrease the likelihood of negatively viewing patients and causing discomfort or harm (Stayton, 1998; Ridley, 2006). Based on this exploration of attitudes, therapists improved their interactions with patients and avoided imposing a negative belief system regarding sexuality onto the patient (Weerakoon & Stiernborg, 1996).

Once therapists understood their sexual attitudes, they were able to create a safe, non-judgmental environment for the client in which—due to the comfort—the client was more open and engaged (Andrews, 2000). Anderson (2002) found that attitude impacts personal bias and attitude, and values were only ascertained and adjusted by awareness. Knowledge was a combination of training and education, and these two components impacted sexual comfort and willingness to discuss sexual health issues. Even those who

did not believe that knowledge impacted comfort found that was one of the important issues in understanding how to improve comfort and willingness to engage (Anderson, 2002). West et al. (2012) found a link between knowledge, comfort, and attitudes toward sexuality as well as a correlation between religiosity and negative attitudes. West et al. also found that social, economic, and gender factors impacted attitudes, further underscoring how complex and complicated attitudes were in their nature. Similarly, Procter (2013) found that religiosity and religious fundamentalism were predictive of negative attitudes toward LGBT clients and damaged the therapeutic alliance. Negative attitudes also impacted how likely the therapist was to refer a lesbian, gay, or bisexual client for services, according to other research (McGeorge, Carlson, & Farrell, 2015).

In Goldstein's (2014) study with 100 students in a Council for Accreditation of Counseling and Related Educational Programs' (CACREP) course, she found that the 60 master's students had less positive attitudes toward transgender and LGB clients than did the 40 doctoral students. The author did not discover a reason for that occurrence but hypothesized that multicultural classes taken by only the doctoral students might have impacted these results. Both masters and doctoral students in both psychology and counseling exhibited positive attitudes toward counseling transgender clients (Goldstein, 2014).

In their study with marriage and family therapists, psychologists, and social workers, Alessi, Dillon, and Kim (2015) found no differences in attitudes toward gay and lesbian clients, "even after controlling for years of practice experience and age" (p. 455). Rather, it was the level of training that was associated with and indicative of a more

positive attitude, self-efficacy, and positive beliefs. Kelsey et al. (2013) studied therapists' attitudes toward bondage, discipline, sadism, and masochism (BDSM) and found that those with more training had more positive attitudes toward treatment and discussion of BDSM with clients. Forty-eight percent of therapists viewed themselves as competent, while 52% did not; therapists with more experience treating clients who engaged in BDSM had more positive attitudes than those who did not have as much experience (Kelsey et al., 2013).

Farmer, Welfare, and Burge (2013) found that counselors in a variety of settings had positive attitudes toward the LGB community but lacked the knowledge and competency to engage their LGB clients about their sexual issues. Parker (2012) found a similar connection between attitudes and training in that the more sexuality-specific training a high school counselor had received, the greater their positive attitudes toward discussing sexual topics with students who also had intellectual disabilities. Furthermore, the level of comfort a high school counselor had to discuss sexuality with students, the more positive his or her attitude was toward discussing sexuality (Parker, 2012).

Psychologists' Attitudes Concerning Sexual Topics

Psychologists' attitudes toward discussing sexual topics correlate with comfort. With permissive attitudes, their comfort levels increased (Hanzlik & Gaubatz, 2012). Attitudes did not only impact comfort, but also their willingness to engage clients regarding a sexual topic (Flaget-Greener, Gonzalez, & Sprankle, 2015). Flaget-Greener et al. (2015) did not find any link between attitudes and sociodemographics (age, sex/gender) clinical education, experience, and specialty in research involving 119

doctoral-level psychologists. Findings in other disciplines showed results in which those variables were impactful. “This…may be explained by the [educational] homogeneity” (p. 19) of the survey participants: Higher levels of education equate with higher levels of permissiveness. These findings were in line with previous research done by Miller and Byers who stated that “a key finding of this study is that attitudes toward sexuality education and training are significant predictors of psychologists’ willingness to assess sexual health” (as cited in Flaget-Greener et al., 2015, p. 20).

Johnson and Federman (2014) also found that attitudes impacted psychologists in their approach to dealing with LGBT issues, including sexual issues, in their study of 384 Veterans Administration psychologists. They found that psychologists from more broadminded regions in the US had more positive attitudes toward LGBT issues, including sexual issues. Psychologists with more positive attitudes also had more training and were open to pursuing more LGBT-specific training. Moreover, younger psychologists who had received LGBT-specific training had more positive attitudes (Johnson & Federman, 2014).

Moreno et al. (2015) found that psychologists had more negative attitudes toward sexuality than did other health professionals. This is in slight contrast to what Alessi et al. (2015) found: no difference in attitudes after controlling for age, practice years, and sociodemographic information between family therapists, psychologists, and social workers. However, given that Moreno et al. (2015) found that these negative attitude levels were similar between the psychologists and social workers involved in their study, this result did not contradict Alessi et al.’s findings. Also, Jabson et al. (2016) found that

psychologists and social workers as a whole had more negative attitudes when compared to physicians.

Willingness to Engage

Health Care Professionals' Willingness to Engage Patients

Physicians do not, as a whole, willingly initiate or engage in sexual topics with their patients. Two studies found that most physicians did not ask sexual health questions during intake visits, mostly due to a lack of training, which negatively impacted medical students' attitudes toward sexual health issues (Cushing, Evans, & Hall, 2005; St. Lawrence et al., 2002). Rheumatology health care providers seldom or never raised sexual topics 71% of the time. This result corresponded to other research in which 88% of health care providers viewed it as the patient's role to initiate discussions of sexuality (Helland et al., 2013).

In another seminal study, Haboubi and Lincoln (2003) found that 94% of the health care professionals surveyed would not initiate sexual discussions, even though the overwhelming majority agreed that sexual health was important and should be addressed. Furthermore, several researchers have found that general practitioners rarely ask about sexual health issues, which correlated with a lack of sexuality training (Byrne, Doherty, McGee, & Murphy, 2010; Laumann et al., 2009; Shepherd, Heke, & O'Donovan, 2009). Stead, Br, Fallowfield, and Sealby (2003) came to a similar conclusion based on a "lack of sexual knowledge and skills, as well as feelings of embarrassment, lack of time, lack of privacy and lack of resources" (p. 670) as the prime reasons for doctors and nurses not discussing sexual health with their patients. Patients perceived doctors as insensitive

when they avoided sexual health questions (Hinchliff, Gott, & Galena, 2005); this perceived insensitivity made patients feel distressed (Dixon-Woods et al., 2002).

In Turkey, nurses were studied using a descriptive and comparative design; researchers found that 68.9% of participants viewed the topic of sexuality as "too private to discuss" with patients (Arikan et al., 2015, p. 327). The majority of these nurses (72.2%) did not see the need to spend time discussing sexuality issues with patients. These researchers used the Sexual Attitudes and Beliefs Scale (SABS) and found a significant correlation between participant's SABS scale score and willingness to discuss sexual issues (the higher the score, the more likely the nurse was to discuss the issues). Moreover, these authors recommended more education, which was a common theme throughout most of the literature (Arikan et al., 2015).

Bal and Sahiner (2015) found similar results in their descriptive design studying Turkish nursing students and determined that the barriers in discussing sexuality with patients were insufficient time, training, or comfort. These researchers also used SABS and found that 80% of nursing students were not willing to give advice even when the patient started the discussion. They concluded that more education on sexuality was necessary to develop this area of medicine (Bal & Sahiner, 2015). Dyer and das Nair's (2013) review of the literature about United Kingdom health care providers (doctors and nurses) revealed an overall theme that health care providers were not interested in bringing up topics of sexuality or engaging in discussion with patients about their sexual health. In Sweden, a study using correlative and comparative design with the SABS instrument using a convenience sample of Swedish nurses found 80% did not start

conversations with patients about sexual health issues and concerns. This number did not correlate with the fact that 66% felt comfortable discussing the topic, according to the survey results (Saunamäki et al., 2010). These researchers recommended more education to improve the nurses' abilities to engage in and provide holistic care to patients regarding their sexual health issues.

The results of the Swedish study were not dissimilar from those found in a study by Vieira et al. (2015) of Brazilian OB-GYNs in which 56% either never or rarely took a sexual history, which would be a natural way to allow the possibility of a discussion about sexuality with their patients. Fifty-one percent did not feel confident or competent to take a sexual history or discuss the topic with a patient. Ninety-one percent of the survey participants had graduated within the past five years and should have had the most up-to-date training. However, 49% received no formal training, and 29% received 6 hours or less during residency. During their doctoral studies, 63.4% had received no sexuality coursework, and 27.9% had 6 hours or less of sexuality coursework or supervision. In other words, the inability for health care practitioners to discuss sex with their patients is not only a Western or Eastern medicine issue but a global issue that needs to be addressed (Vieira et al., 2015).

In a review of three decades of research with oncology nurses (18 articles) in a meta-analysis, the authors found that oncology nurses rarely discussed sexual health topics with patients for a variety of reasons: limited sexual knowledge, incorrect assumptions, lack of comfort, and society-related factors (Kotronoulas et al., 2009). Levesque (2013) used a descriptive design with convenience sampling to study nurse

practitioner students' knowledge, attitudes, and self-efficacy. Levesque found that students had positive attitudes, but little knowledge and low self-efficacy toward transgender patients (i.e., they were unlikely to initiate the discussion with the patient). Magnan and Reynolds (2006) studied barriers to discussing sexual health with nurses across five nursing specializations (OB/GYN, oncology, medicine, surgery, and rehabilitation) and found that nurses thought patients did not want them to discuss sexual topics. This was the leading barrier across all nursing disciplines. The next major barrier was lack of time.

Maciel and Laganà (2014) designed a study to examine a different aspect of the sexual health discussion: How often did OB-GYNs discuss older women's sexuality with them? They found that two-thirds routinely asked patients about their sexual activity, 40% asked about sexual concerns or dysfunctions, and 29% asked about sexual satisfaction. The authors noted that when clinicians did not raise sexual topics, the patients determined that these topics were not appropriate and should not be discussed causing further anxiety and unmet needs. Ninety-seven percent of the older female participants wanted to discuss sexual issues with their treating OB-GYN (Maciel & Laganà, 2014).

The Maciel and Laganà (2014) result was conflicting slightly with an earlier study by Pauls et al. (2005) examining 471 member-physicians of the American Urogynecologic Society. Sixty-eight percent were familiar with treating sexual dysfunction in women, 47% thought sexual health screening for dysfunction was somewhat important, and 42% believed it was important. However, 13% used

questionnaires for screening purposes, 22% always screened for dysfunction using questionnaires or in-person discussion, 55% screened most of the time, and 23% never screened or discussed sexual dysfunction with patients at all. The study authors stated that sexual issues were reported at a higher percentage and were "more prevalent in females (43%) than males (31%)" (p. 460).

Only 33% of physicians involved in the treatment of patients with amputations addressed sexual health in any way (Verschuren et al., 2013). Verschuren et al. (2013) used the Knowledge, Comfort, Approach, and Attitudes toward Sexuality Scale (KCAASS) in a Dutch-adapted form to conduct their study. KCAASS was originally developed for assessing physicians interacting with spinal cord injury patients. Verschuren et al. (2013) analyzed the data by "using chi-squared-tests, independent sample *t*-tests and one-way analysis of variance (ANOVA) with a least significant difference (LSD) post hoc test." Then, Verschuren et al. (2013) measured the effect size using Cohen's *d* and "Multivariate logistic regression analysis (stepwise backward) was used to predict the odds of receiving a question about sexuality or address the issue of sexuality" (p. 1699).

Moreno et al. (2015) examined how 16 men and 22 women who were, on average, 2.6 years out from traumatic brain injuries, had experienced care regarding their sexual health. The data revealed a low frequency of discussion about sexual health or reproductive issues; their sexual needs went largely unaddressed and unmet. Participants viewed the discussion of sexual topics as the treating physician's role to raise with them

and not the role of a family physician, psychologist, general practitioner, or other health care professionals (Moreno et al., 2015).

Counselors' and Therapists' Willingness to Engage Patients

There is a dearth of literature on the willingness of counselors and therapists to engage clients in discussion of sexual topics (LoFrisco, 2013). Harris and Hays (2008) did the original, seminal study prompting an ongoing conversation within the community of therapists about how this variable impacted practice (Cupit, 2010; LoFrisco, 2013). Harris and Hays (2008) did not make a distinction in their research, however, between graduate-level supervision and postgraduate supervision of counselors. This distinction is important due to the duration involved with each and is significantly different. Therefore, level of education could impact the comfort and willingness to engage clients on sexual issues.

Certified rehabilitation counselors who work with autism spectrum disorder (ASD) patients were willing to discuss sexual topics with their patients and were comfortable while discussing sexual topics with their patients (Easton, 2015). Gender was not a factor in comfort or willingness; subjective normative beliefs, perceived behavioral controls, and attitude were the variables that had strong correlations with a willingness to engage as a whole. Attitudes toward sexuality and ASD did not have a strong correlation. Easton (2015) reasoned that this outcome was influenced by the fact that the framework used for the study had not been applied before and the sample was small and homogenous. Easton encouraged further study using social cognitive theory as the framework to examine counselors' attitudes toward sexuality.

In their research with practicing certified rehabilitation counselors, Juergens et al. (2009) found that "sexuality knowledge, sexuality education, attitudes toward the sexuality of people with disabilities and comfort with sexuality affect the willingness of rehabilitation counselors to discuss sexuality with clients with sexuality knowledge and comfort with sexuality" had "direct effects on willingness among participants" (p. 113).

Cupit (2010) found that the more comfortable counselors were, the more likely they were to engage the client. A significant correlation was found (r =.19, p<.01) between sexual attitude (idealistic) and sexual comfort. Other sexual attitudes (i.e., attitudes toward birth control, sexual attitudes toward permissiveness and instrumentality, strength of religion, and graduate specialization) did not result in a correlation. Correlations were only found in the following variables with sexual comfort: sexual attitudes regarding idealistic sexuality, human sexuality training, and supervision experience in the area. While not all attitudes have a correlational relationship with sexual comfort or with a willingness to engage, delineating which attitudes are associated with a willingness to engage is important. Cupit found that the older counselors were, the more willing they were to engage, while Harris and Hays (2008) found that age was not impactful. This dichotomy of results is seen throughout the literature with some researchers finding that gender or age was impactful, while others did not, suggesting the need for further research. For example, Decker (2010) did not find a connection between demographic variables, such as age, and willingness to engage, but did determine that experience impacted and affected a therapist's willingness to engage a client regarding a sexual topic. Decker found that experience influenced comfort and that this had an impact

on willingness to engage; in contrast, age, experience, and training did not impact comfort.

Yelton and Delfin (2015) found that 36% to 64% of mental health counselors were willing to initiate a sexual topic discussion with a client. The percentages varied based on the disciplinary background, with social workers having the lowest willingness to initiate. With only 75 participants derived using convenience sampling, these results may not be a true reflection of the overall area of practice (Yelton & Delfin, 2015).

Psychologists' Willingness to Engage Patients

In their study of 110 practicing US and Canadian psychologists (83.6% of whom were clinically-focused, and 16.4% of whom were counseling-focused), Miller and Byers (2012) found that sexuality was not often brought up or addressed and older psychologists were slightly more willing to engage clients about sexuality. Miller and Byers used Bandura's theoretical framework for understanding and interpreting the results based on how self-efficacy impacted the process. They concluded that an increase in knowledge germane to sexuality and postgraduate sexuality-focused workshops and other educational opportunities were key to increasing self-efficacy and increasing willingness to engage patients about sexual topics.

Træen and Schaller (2013) examined the predictive factors for willingness to discuss sexual issues with their patients in a sample of Norwegian psychologists. Their data revealed that attitudes and beliefs were the predictive factors after controlling for age, gender, years of practice, and training in sexology. Older, more experienced psychologists were more willing to discuss sexual issues. However, one in five reported

that they often or always engaged their clients about their sexuality. This result was similar to Miller and Byers's (2012) results.

Hanzlik and Gaubatz (2012) focused their study on the comfort of PsyD students when discussing sexual issues with clients; these participants were not willing to engage with clients on sexual topics. Furthermore, male clients who saw female therapists may "…suffer from the tacit minimization or even outright avoidance of their sexual concerns." The authors found this concerning since an ever-increasing number of female psychologists are entering the field (Hanzlik & Gaubatz, 2012, p. 229).

Knowledge

Health Care Professionals' Knowledge Regarding Sexual Topics

Reflected in the literature was an overall lack of knowledge regarding sexuality among all involved in health care, therapy and counseling, and psychology. This lack of knowledge represents a barrier to communication with patients and clients (Bal & Sahiner, 2015). The following literature is representative of this widespread phenomenon.

In a study of Turkish nurses, Bal and Sahiner (2015) found that lack of sexual knowledge was a barrier to communication with patients about their sexual issues. Nurses attitudes were positively impacted regarding communicating with patients about sexual health concerns with training and knowledge. In Haboubi and Lincoln's (2003) analysis of 813 replies from nurses to their survey, they found that previous training in sexuality was low at 14%, while 86% had no training or little training. Of the respondents who had undergone training, 53% thought it had improved their knowledge and practice, 27%

thought it had just improved knowledge, and 20% thought it had been of no use, which may be more reflective of the instructors than their opinions regarding training.

In their research, Banwari et al. (2015) used the Attitudes toward Homosexuals Questionnaire (AHQ) and the Sex Education and Knowledge about Homosexuality Questionnaire (SEKHQ) and analyzed the results using multiple linear regression. The results were only applicable to the Indian physicians who participated in their survey, but the authors noted that these results were in line with American and Canadian knowledge bases, with a slightly more biased framework concerning homosexuality because of cultural factors.

Saunamäki et al. (2010) surveyed Swedish registered nurses using the SABS; 90% of those surveyed understood the importance of sexual health and concerns of patients. However, 60% did not feel confident discussing these topics due to a lack of competency and knowledge. Saunamäki et al. argued for further education as a means to increase knowledge for nurses dealing with patients regarding sexual concerns.

Vieira et al. (2015) studied Brazilian OB/GYN residents, 49% of whom had received no training up to that point regarding sexuality, with 29% reporting having received 6 hours of training or less. Fifty-six percent never or rarely took a sexual history, and 51% did not feel competent to do so. The authors concluded that there was an immediate need for sexually-specific training for medical students and residents.

In research conducted in the southeast US, 38% of medical students had received no sexuality training (Valvano et al., 2014). Helland et al. (2013) surveyed individuals working in a variety of disciplines—nurses, physicians, physiotherapists, occupational

therapists, social workers, and psychologists—and found that 53% of those surveyed stated that lack of knowledge was a significant barrier. The professionals who had more education in sexuality initiated the discussion with patients more often and were more comfortable in the process. Haesler et al. (2016) studied health care professionals' attitudes and knowledge toward older patients' sexuality. These practitioners did not have sufficient knowledge and considered older patients' sexual health to be beyond their scope of practice. In other words, lack of knowledge was a barrier.

Kotronoules et al. (2009) conducted a comprehensive meta-analysis of the literature, examining 18 studies over three decades regarding oncology nurses and sexuality. Oncology nurses had positive attitudes, but limited sexual knowledge; this was a barrier to discussing sexual health issues with patients.

Lapinski et al. (2014) studied attitudes, knowledge, and acceptance of LGBT patients by 1335 osteopathic medical students using the Klein Sexual Orientation Grid and the Homosexuality Attitude Scale. The participants reported favorable attitudes and acceptance levels; these were higher in those who self-identified as LGBT. "Only 125 respondents (12.9%) obtained a passing score" on the section testing medically relevant knowledge of sexual issues (p. 792). While the LGBT self-identified students' scores were higher than their heterosexual peers, the study results suggested that students lacked adequate knowledge for the competent treatment of sexual health issues for the LGBT community.

Levesque (2013) conducted a similar study of 416 nurse practitioners with the variables being self-efficacy, attitudes, and knowledge, but used the Attitudes Toward

Transgender Survey and Health Care Provider Survey by Burch (2005) to understand the nurse practitioners' perspective. Nurse practitioners lacked both knowledge and self-efficacy; a result, the authors argued, that impacted their ability to interact with and engage transgender patients on sexual health issues. Kline (2014) found a similar result when he surveyed 80 nurse practitioners, 80% of whom agreed they needed more training to serve the transgender community competently. Riggs and Bartholomaeus (2016) surveyed Australian mental health nurses using the Attitudes Toward Transgender Individuals Scale and Counselor Attitude Toward Transgender Scale and found that those who had undertaken training on transgender health issues had a higher knowledge than those who had not been trained. The survey results also indicated a correlation between older age and higher knowledge, as well as between female nurses and higher knowledge. Although limited by its small sample size (n=96), the study authors believed that it was generalizable to the larger mental health nursing population, including in the United States and Canada. In Sidi et al.'s (2013) research involving Malaysian medical students regarding general sexual health knowledge and attitudes, 73.2% of those surveyed reported that "they had not received adequate training," (p. 107) education, and knowledge regarding how to deal with sexual health issues in the measures used. Fifty-five percent had adequate sexual health knowledge. Sidi et al. stressed the importance of integrating sexual health training and education into the core of the medical school curriculum and noted that integration could achieve more positive attitudes and higher knowledge while reducing the likelihood that therapists would not overlook patient' sexual health concerns or leave them unaddressed.

There are few studies designed to examine sexual training and its long-term effects. One of the few was a longitudinal study designed by Fronek et al. (2011) as a follow-up (2 years later) to a randomized controlled study regarding training for rehabilitation practitioners working with people who had experienced spinal cord injuries. The researcher found that training had a long-lasting impact on practitioners' knowledge, attitudes, and comfort. Fronek et al. noted that the more focused the training was to the discipline and the individual needs of the practitioners, the more likely the positive effects would be impactful and lasting.

Using the KCAASS, Verschuren et al. (2013) studied physicians' knowledge regarding sexual health issues and how often these issues were addressed for patients with lower limb amputation. The participants rated their knowledge as almost sufficient, but the results from the instrument indicated that their knowledge was, in fact, sufficiently competent. Despite having sufficient knowledge, Verschuren et al. (2013) still recommended more training specific to sexual knowledge to increase overall sexual knowledge and to improve the comfort, competency, and willingness of physicians to engage with patients on sexual topics. West et al. (2012) also encouraged implementation of curriculum focused on sexual health and related issues for medical students due to the impact of knowledge on other important variables including attitude, skill, and comfort.

Higgins et al. (2012) conducted a mixed methods study with health care providers, using a pre-test and post-test survey and interviews after a 1-day training program had been presented to participants. Data were analyzed using *t*-tests. The researchers found marked improvement for health care providers who

participated in the program concerning their knowledge, comfort, and skill when discussing sexual topics with patients.

Strong and Folse (2015) did a similar training intervention designed to improve undergraduate nursing students' attitudes and knowledge regarding LGBT patients. Strong and Folse's intervention was not about sexual health issues in general, but rather was focused on the medical needs of transgender patients, including their sexual health concerns. The Attitudes Toward Lesbians and Gay Men Scale was used, which had high internal consistency as determined by Cronbach's alpha, and high reliability (α=.95). The authors used two other instruments they had developed; the post-test results revealed a statistically significant increase in knowledge on all 15 items and revealed positive attitudes toward the LGBT patient community.

In Taiwan, Sung and Lin (2013) used a 12-week-long educational intervention for a quasi-experimental study using both control and experimental group. Both groups were comprised of 95 nursing students. The researchers analyzed the longitudinal results from the pre-tests and post-tests, using the hierarchical linear model. The results of the intervention were both positive and statistically significant. The results revealed that the students in the experimental group showed significant improvements over those in the control group on knowledge (β=−0.27, P<0.001), attitude (β=−0.38, P<0.001), and self-efficacy (β=−0.90, P<0.001)" (p. 498).

Tugut and Golbasi (2015) designed an educational intervention—a total of 18 hours presented over 3 days—to the experimental group of Turkish nursing students. Participant assignment to the experimental group or the control group was randomized.

The researchers assessed the students' attitudes, knowledge, and skill by using the "Sexuality Assessment Information Test, Sexual Attitude and Beliefs Scale, and Sexuality Assessment Skills Check List" (p. 1). After the intervention, the scores of "the experimental group [were] significantly higher than mean scores of students in the control group ($p < .05$)" (p. 1). Tugut and Golbasi highlighted the importance sexual health was to a complete understanding of how to interact with and assess patients' needs and to engage in a holistic practice of medicine. The educational component regarding sexual health was found lacking. The nursing students did not have the necessary informational base upon which to rely when engaging with patients. This, in turn, formed a barrier, which with proper training, was overcome.

Simpson, Anwar, Wilson, and Bertapelle (2006) found marked improvement after training staff members who worked with patients having neurological disabilities. In this experimental study (with control and experimental groups), Simpson et al. used the Sexual Attitude Scale, the Role Skills Intervention Survey, a single item for comfort, and an author-designed knowledge assessment. The experimental group and control group had similar pretest scores but significantly different posttest scores; the gains from the experimental group were also found six months later. The staff who had been in the experimental group were found to engage patients more often about sexual health issues and were more knowledgeable.

Similar positive results were not observed among Tennessee physicians from two hospitals in a study designed to determine the impact of training and mandatory protocols regarding anti-discrimination for the sexual and gender minority community (SGM)

(Jabson et al., 2016). Although one hospital had implemented these protocols and training, there was no significant difference in knowledge or treatment of SGM patients found between the physicians who had taken the training and those who did not. The authors recommended more research into affirmative practices that might help the SGM community to discover a more effective way to minimize or eliminate discrimination against SGM patients.

Counselors' and Therapists' Knowledge Regarding Sexual Topics

Harris and Hays's (2008) research into the willingness of marriage and family therapists to engage their clients as impacted by the variables of sexuality knowledge and comfort was a seminal article on this topic and is the most often cited resource. The authors found that sexuality knowledge and supervision, with training specific to sexuality, influenced the willingness of therapists to engage their clients. While Harris and Hays's (2008) findings conflicted with Decker (2010) regarding how knowledge impacted comfort, both Decker, Harris, and Hays agreed that supervision was a cornerstone upon which the foundation of a great therapist, willing to engage and discuss sexual health issues with patients, was laid. Harris and Hays highlighted the importance of graduate-level sexuality education and training because it impacted the comfort and willingness of therapists to interact with clients and decreased the anxiety inherent in discussing this topic. Harris and Hays used the Bowenian theoretical framework for their research on this topic; the only study to do so.

Decker (2010) focused her dissertation on supervisors and how they addressed the needs of clients regarding sexuality; the supervisors had sufficient knowledge in nine of

15 areas regarding the sexual health needs of clients. Decker found that over 70% of supervisors recommended trainees include sexuality as a consideration and 50% recommended that trainees take a sexual history of their clients. The supervisors who had sought out graduate courses or postgraduation training in sexuality areas reported having more knowledge. However, a correlation between knowledge and comfort was not found, conflicting with other studies, including Harris and Hays (2008), who did find a correlation between knowledge and comfort. Decker noted the dearth of research in this area, which prompted her to create the survey instrument she used in her research.

In contrast, Kazukauskas and Lam (2010) found a correlation between comfort and knowledge among their certified rehabilitation counselor participants; as knowledge increased, comfort increased as well. While participant data showed average knowledge, there was also a need for further education to increase competency, decrease approach anxiety, and improve the quality of care.

Pebdani (2013) conducted a similar study regarding rehabilitation master's program students using the same instruments as Kazukauskas and Lam (2010) and found that training had a significant impact on knowledge regarding sexual needs of patients who were going through rehabilitation. Pebdani noted that these findings were consistent with the prior research and that training focused on sexuality improved sexual knowledge of the counselors who then, as demonstrated by Juergens et al. (2009), were more willing to engage patients and were more comfortable in the process.

Farmer et al. (2013) studied 468 school and community counselors' competency with LGB knowledge and attitudes. Participants' requisite knowledge was lacking

regarding how to interact with and address the needs of this population. School counselors were shown to have lower scores than their community colleagues in this area. Farmer et al. noted that these findings were consistent with previous research where there was a general lack of knowledge.

In a meta-analysis of marriage and family therapists, Dermer and Bachenberg (2015) addressed the fact that no significant advancement by marriage and family therapists has been made regarding treatment of clients' sexual health needs and concerns; neither has therapists' comfort in discussing sexuality with clients. Furthermore, there has not been a call to change the educational structure so these skills and knowledge can be acquired.

Psychologists' Knowledge Regarding Sexual Topics

There is also a lack of literature on the topic under discussion in the field of psychology. Several of the following studies were conducted in other disciplines but included psychologists as participants.

Flaget-Greener et al. (2015) conducted a survey of "119 doctoral-level psychologists licensed in the US, who reported to be the members of the American Psychological Association (APA)" (p. 13) to discover whether education, training, sociodemographic characteristics, and attitudes had any impact on their willingness to engage clients in sexual topics. Flaget-Greener et al. did not find a link or correlation between education and attitude toward treating older individuals' sexual health concerns. The authors noted that this might have been due to the homogeneity of the participants: Permissive attitudes tend to correlate with higher education. Flaget-Greener et al. found

"that attitudes toward older adults' sexuality and sexual education and training were predictive of psychologists' willingness to assess older adults' sexual health, despite participants' demographic characteristics" (p. 19). They concluded that a key component in increasing psychologists' willingness to engage is to increase training specific to sexuality and sexuality education, along with changing attitudes.

In a study of 384 Veterans Administration psychologists, participants completed a survey regarding their attitudes and knowledge, needs and interests in training, self-reported competence, current practice, experience, and training regarding LGBT patients (Johnson & Federman, 2014). Data indicated that 83.6% had attended one course or less regarding transgender issues; 55.8% had one class period or less on sexual orientation issues. Over 55% did not ask questions about sexual orientation to aid their treatment options, 92% did not ask about gender identity. Johnson and Federman (2014) noted the significant relationship between training specific to LGBT issues in graduate school and the long-term positive effects this training had on attitudes and experience. These results underscore the importance of knowledge acquisition.

Valvano et al. (2014) found that psychology students received the least amount of classroom hours focused on sexuality when compared to the other allied health disciplines: 69% received no sexuality education on how to interact with clients about their sexuality. This was compared to 9% of nurses who had not received a similar education. The authors also found that medical students had the highest number of direct contact with patients (only 38% had no hours of direct contact) regarding sexual health issues, while psychology students had the least (94% had no hours of direct contact).

Psychology students seemed to be aware of this by rating their quality of education regarding sexuality significantly lower ($M = 2.06$, $SD = 1.01$) than their medical student peers ($p < 0.01$ for all comparisons). Valvano et al. also noted that students not only lacked sufficient quantity, but the quality of sexuality education was also lacking. The authors argued that this lack resulted in psychologists who were ill-equipped to handle such discussions and would not be confident in their ability to do so. Valvano et al. urged that curriculum devoted to sexuality, sexual health, and direct contact with clients be integrated into the educational paradigm. Their conclusion was consistent with Decker's (2010). Despite the fact that Decker was examining counselors in her study, it would seem appropriate to consider her conclusions in light of Valvano et al.'s recommendations.

Summary and Conclusions

In summary, the literature pointed out that marriage and family therapists are not meeting the needs of their clients, that this need is pressing, and that failure to meet the need could cause damage (Cupit, 2010; Harris & Hays, 2008; Juergens et al., 2009; LoFrisco, 2013; Papaharitou et al., 2008; Timm, 2009). This is not a unique problem to the marriage and family therapy profession because a wide variety of health care and medical professions are currently dealing with similar problems of failing to engage and address sexual health issues (Helland et al., 2013; Kotronoulas et al., 2009; Verschuren et al., 2013; Vieira et al., 2015)

In conclusion, no studies were found that included the independent variables of knowledge and attitude to determine the effect on the dependent variables of comfort and

willingness to engage clients in sexual discussions for marriage and family therapists. Furthermore, no researchers used the instruments in the manner I proposed: to determine what impact, if any, knowledge and attitude have on comfort and willingness to engage clients about their sexual lives and experiences by the marriage and family therapists surveyed. The need for this study is further strengthened by the lack of studies in this area (Cupit, 2010; Decker, 2010; Harris & Hays, 2008; LoFrisco, 2013; Miller & Byers, 2012; Yelton & Delfin, 2015). The methodology chosen for this study, which follows similar design and method choices of Cupit (2010) and Harris and Hays (2008), is discussed in Chapter 3.

Chapter 3: Methodology

The purpose of this study was to examine the variables that affect marriage and family therapists' willingness and comfort to engage in and discuss the topic of sexuality with clients to whom they provide therapy. The overarching research question was the following: How can therapists' increase their levels of comfort and their willingness-to-engage so clients' care does not suffer and therapy is a positive experience conducted in a protective environment? The two dependent variables investigated were (a) therapists' comfort in discussing sexual topics, and (b) therapists' willingness to engage and discuss sexuality with clients. The independent variables that were measured were therapists' (a) attitudes, (b) knowledge, (c) training, (d) supervision experience, (e) clinical experience, (f) sex, (g) age, (h) strength of religion, (i) sexual orientation, (j) practice experience, (k) practice setting, (l) graduate specialization, and (m) relationship status.

This study was quantitative and correlational and was derived from the methods from Cohen, Manion, and Morrison (2007). I consulted Bowen and Kerr (1988) for guidance regarding the use of Bowenian theory, and Harris and Hays (2008) for how I should treat the variables within a Bowenian framework.

In Chapter 3, I explain why the correlational design was appropriate and describe the study instruments. I also provide the rationale, population, sample size, and sampling procedures for the study. Next, I provide information on data collection, measurement instruments, operationalization of variables, data analysis, and threats to validity. Finally, I address ethical issues and procedures used to mitigate any concerns.

Research Design and Rationale

The purpose of this study was to examine how the independent variables of sexual knowledge, training, supervision, clinical experience, and personal sexual attitudes of therapists influence their comfort and willingness to engage in and discuss the topic of sexuality with a client. The study purpose dictated the research methodology and the associated design that I used (see Conrad & Serlin, 2005; Edmondson & McManus, 2007). Harris and Hays (2008) and Cupit (2010) used quantitative methodology for similar research. I designed the current study to determine the specific factors that influence a particular outcome and to identify the best predictors of therapists' willingness to engage in topics of sexuality and therapists' comfort discussing sexuality with clients. I considered a quantitative approach as best suited for the study's purpose (see Creswell, 2009).

A qualitative approach was not suitable for this study because the issue of therapists not being comfortable and not being willing to discuss sexual issues with clients was not new (see Harris & Hays, 2008). The variables necessary to examine the relationships between sexual knowledge, training, supervision, clinical experience, sexual attitudes, sexual comfort, and willingness to engage and discuss sexual topics were well known and did not require an exploratory approach (see Creswell, 2009). Because these variables were known, I could measure the predictive relationships among them.

I used a cross-sectional correlational survey design because this design lends itself to research and analyzing predictive relationships among variables (see Creswell, 2009). This type of survey design was appropriate for identifying correlations (see Marczyk,

DeMatteo, & Festinger, 2005; Monette, Sullivan, & DeJong, 2007). The cross-sectional survey design is the typical choice for this type of research, requiring less time to finish and fewer resources (see Carlson & Morrison, 2009; Polit & Beck, 2006). The survey design is also an appropriate choice when standardized instruments are used for data collection from a large number of participants who live in different geographical areas (see Creswell, 2009; Kothari, 2004). The cross-sectional design allows for the generation of a hypothesis from the variables assessed, which allows for the addition of knowledge to the topic area and for further research (see Carlson & Morrison, 2009).

I did not add a longitudinal dimension to this study because of the lengthy follow-up process that would have been required, as well as the cost associated with such a study (see Aschengrau & Seage, 2008). One of the benefits of the chosen design was there were no issues from participants dropping out that could have skewed the results (see Aschengrau & Seage, 2008). Although this design did not allow for causation to be established among the variables and the survey approach may have resulted in low internal validity, the design allowed for precise findings that yielded answers to the research questions (see Creswell, 2009; Frankfort-Nachmias & Nachmias, 2008; Szklo & Nieto, 2014).

Population

The population from which I drew the participants were state-licensed, active, marriage and family therapists who provided therapy to clients. Participants were actively engaged in therapy with clients and were not engaged in other types of employment, such as teaching. This population was finite: There are 32,070 marriage and family therapists

practicing in the United States, according to the most recent Bureau of Labor Statistics from May 2016 (U.S. Department of Labor, Bureau of Labor Statistics , 2017).

Sampling and Sampling Procedures

I used random sampling in this study (see Frankfort-Nachmias & Nachmias, 2008). Simple random sampling is a probability-based sample design that I used to ensure every U.S. marriage and family therapist had "an equal and nonzero probability in being selected" (see Frankfort-Nachmias & Nachmias, 2008, p. 169). I drew the sample from a list of marriage and family therapists practicing in the United States, who were licensed in their state, who possessed a master's or doctoral degree, and who were active in their profession. This list was available for purchase online.

Determining the sample size necessary to provide accurate results was based on three factors. The first was the power of statistical analysis (see Kuehl, 2000). The second was effect size, which measured the relationship between the independent and dependent variables and the magnitude that resulted. Level of significance was the third factor that impacted the sample size. I used G*Power to determine the necessary minimum sample size based on a level of significance. I used a high power of 0.95, a medium effect size equal to $f^2 = 0.15$, and a significance level of 0.5. The total number of predictors was two, and I used a 95% confidence level with a confidence interval of ±5%. Given these parameters, the minimum sample size was 107 as computed with G*Power using the F test for multiple linear regression with the fixed model and R^2 deviation from zero.

A type II error (Merriam-Webster, n.d.) can occur when doing statistical analysis (Frankfort-Nachmias & Nachmias, 2008). To guard against this failure to reject a false

null hypothesis, which can be attributed to inadequate sample size, I included at least 110 participants in the analysis (see Frankfort-Nachmias & Nachmias, 2008). Therefore, at least 110 marriage and family therapists had to complete and return the surveys. I chose the participants at random from the email lists, and I expected about 10-15% to be returned based on previous literature. To achieve this goal of 110 surveys completed by marriage and family therapists, I emailed the survey to 2,000 marriage and family therapists to meet the minimum sample size, as computed by G*Power, necessary to reduce the chances of a type II error occurring during the statistical analysis.

Procedures

Survey Monkey is an online service available free of charge that I used to design and create the survey for this research. I composed an e-mail invitation to potential participants, e-mailed the survey link to those who accepted the invitation, and collected the responses. Step 1 in this process was to convert the existing instruments into the Survey Monkey's questionnaire format. Step 2 was to compose an e-mail explaining the study and send the email to 2000 potential participants to solicit their participation. The survey explanation included an outline detailing the purpose of the study and how I would maintain anonymity. I required informed consent from each participant before starting the survey; the participants affirmed their voluntary participation and understanding that they were free to quit at any time if they felt uncomfortable or otherwise compromised before gaining access to the survey. I did not use follow-up procedures in this study. I tracked the results on Survey Monkey, verified the data to

ensure no corruption or errors occurred in its transmission (Step 3), and analyzed the data using Statistical Package for the Social Sciences (SPSS) 24 (Step 4).

Instrumentation and Operationalization of Constructs

Demographic Data

Cupit (2010) developed the demographic data instruments that I used in this study. The author used this instrument when studying "counselors who were members of the American Counseling Association" (p. 13). The variables measured by this instrument were sex, age, strength of religion, sexual orientation, practice experience, practice setting, graduate specialization, and relationship status. Published reliability and validity values were not relevant because I used this instrument to collect demographic information about the participants.

24-Item Miller-Fisk Sexual Knowledge Questionnaire

Warren Miller and Norman Fisk developed the original 49-item Miller-Fisk Sexual Knowledge Questionnaire in 1969, consisting of questions related to sex drive, fertility, reproduction, contraception, and menstruation (Gough, 1974). I used a shortened version of this instrument, the 24-Item Miller Fisk Sexual Knowledge Questionnaire, in the current study. The questions on this instrument were either true/false or multiple choice with four options. I based the total score on the correct number of answers, and a high score indicated sexual knowledge. An example item was "Withdrawal is an effective means of contraception (birth control)" with a true/false answer.

This shortened version was tested for validity in a study that involved 209 male participants and 146 female participants in Sample 1, and 78 male participants and 100

female participants in Sample 2 (Gough, 1974). Statistical significance was found at every point-biserial coefficient when measured in the .01 level; internal consistency was found to be sufficient (Gough, 1974). In follow-up research, 355 students were tested for odd-even reliability coefficients; the corrected coefficients were found to be .62 for female participants, .70 for male participants, and .67 overall (Gough, 1974). The mean for the male participants was 15.51, with an *SD* = 3.77; the mean for the female participants was 16.55, with an *SD* = 3.47 (Gough, 1974). The overall mean was 15.94 with an *SD* = 3.69 (Gough, 1974). The 1.04 difference between the two sexes gave a *t* ratio of 2.68, $p \leq .01$ (Gough, 1974). Cupit (2010) subsequently used this instrument as did Russell, Gates, and Viggiani (2016) in the most recent research on mental health counselors' attitudes and knowledge toward sexual health issues.

Sexual Comfort Scale

Harris and Hays (2008) developed the Sexual Comfort Scale and used it in their initial study using a 7-point Likert-type scale (1 = *uncomfortable*; 7 = *comfortable*) to measure how comfortable a therapist would be discussing sexual topics with clients. An example item was "I respond openly and confidently when my sexual values are challenged." The Sexual Comfort Scale was appropriate for this study because I aimed to survey marriage and family therapists using the same variables as those used by Harris and Hayes (2008); my research was an extension of their work. Harris and Hays (2008) found the Cronbach's alpha at 0.86 but there was no validity or reliability data beyond that for this instrument.

Brief Sexual Attitudes Scale

Hendrick, Hendrick, and Reich (2006) developed the Brief Sexual Attitudes Scale (BSAS), which was an update to the authors' previous scale, the Sexual Attitudes Scale (SAS). The BSAS was appropriate for this study because several researchers had used it to measure the sexual comfort of mental health professionals (see Cupit, 2012; Hanzlik & Gaubatz, 2012). The subscales of the BSAS include birth control, permissiveness, instrumentality, and communion.

Hendrick et al. (2006) designed the BSAS with a 5-point, Likert-type scale from 1 = *strongly agree* to 5 = *strongly disagree*. Low scores indicated permissive sexual attitudes. Example items were "I would like to have sex with many partners" or "Casual sex is permissible." I used this scale to measure sexual attitudes of the marriage and family therapists in the current study.

Hendrick et al. (2006) used three different samples to measure the reliability and validity of the BSAS. The authors drew the first sample from 674 undergraduates from a university in the southwestern portion of the United States, and the resulting four subscales' alphas were birth control = 0.84, permissiveness = 0.93, instrumentality = 0.77, and communion = 0.71. This was consistent with previous alphas from the original SAS. The BSAS "performed similarly to the original scale (and consistently with previous research) when correlated with the other scales" (Hendrick et al., 2006, p. 81).

Hendrick et al.'s (2006) second study included 528 participants enrolled at the same university who were in a psychology course. Hendrick et al. compared the SAS with the BSAS and found a 0.98 on a goodness of fit index. The chi-square test indicated

that the difference between the scales was highly significant ($p < 0.001$). The alphas for the subscale were birth control = 0.87, permissiveness = 0.95, instrumentality = 0.80, and communion = 0.79; the correlations drawn from the BSAS were comparable to the SAS.

Hendrick et al.'s (2006) third and final study also drew participants from the same university and they also selected 518 participants from psychology students who were in the introductory phase. The test–retest reliability was found 0.20 or lower when measured. The alphas were birth control = 0.88, permissiveness = 0.95, instrumentality = 0.77, and communion = 0.73 with the retest as follows: birth control = 0.57, permissiveness = 0.92, instrumentality = 0.75, and communion = 0.86. The subscales included 10 items for permissiveness, three items for birth control, five items for communion, and instrumentality with five items.

Sexuality Education Scale

Harris and Hays (2008) developed the Sexuality Education Scale, which consists of seven items. For example, Harris and Hays and Cupit (2010) both used this scale in their research with marriage and family therapists and counselors respectively regarding the variables in this study. "There are no reliability or validity data on this scale" (Cupit, 2010, p. 72). However, Harris and Hays found it suitable (Cupit, 2010).

Experience in Supervision Scale

The Experience in Supervision Scale was developed to measure the number of interactions therapists had while being supervised that involved discussions of sexuality (Harris & Hays, 2008). Cupit (2010) and Harris and Hays (2008) also used this instrument in their studies of marriage and family therapists and counselors respectively

regarding the variables in the current study. “There is no reliability or validity data for this scale” (Cupit, p. 73).

Clinical Experience Scale

Harris and Hays (2008) created the Clinical Experience Scale to assess the aggregate experience therapists had in clinical settings discussing sexual issues. Cupit (2010) and Harris and Hays also used this instrument in their studies of marriage and family therapists and counselors respectively regarding the variables in the current study. “There is no reliability or validity data for this scale” (Cupit, p. 73).

Sexuality Discussion With Clients Scale

Harris and Hays (2008) developed the Sexuality Discussion with Clients Scale to assess the willingness of therapists to engage in discussions with clients about sexual topics. It was appropriate for this study because Harris and Hays and Cupit (2010) had used it in their study of marriage and family therapists and counselors respectively regarding the variables I am examining. Cronbach’s alpha was 0.90 in Harris and Hays’s study; there was no other data regarding the validity or reliability of this instrument.

Operationalization

I measured sexual knowledge using the 24-item Miller-Fisk Sexual Knowledge Questionnaire (see Gough, 1974). The participants answered the questions as true/false or multiple-choice with four options. I based the total score on the correct number of answers where a high score indicates sexual knowledge. An example item is “Withdrawal is an effective means of contraception (birth control)” with a true/false answer.

I measured sexual attitudes using the BSAS, which is a Likert-type scale consisting of a 5-point spectrum (see Hendrick et al., 2006). Participants indicated the extent of their agreement or disagreement on this sliding scale. A lower score indicated a permissive attitude toward sexuality from 1 = (*strongly agree)* to 5 = (*strongly disagree*). An example item statement is "I would like to have sex with many partners" or "Casual sex is permissible." I used this scale to measure marriage and family therapists' sexual knowledge.

I measured sexual comfort using the Sexual Comfort Scale (SCS) (see Harris and Hays, 2008). Hays (2002) developed it by using a 7-point Likert-type scale to measure how comfortable a therapist would be discussing particular topics with clients. An example item is "I respond openly and confidently when my sexual values are challenged" with a scale of 1 = *(uncomfortable)* to 7 = *(comfortable).* The higher the score, the more likely the therapist would be comfortable with discussing sexual issues with clients. I used this scale to measure marriage and family therapists' sexual comfort as it related to the therapy setting.

The Sexuality Education and Supervision Scale is a mix of multiple choice, using a 7-point Likert-type scale with single answer questions, i.e., what is your gender? (Harris & Hays, 2008). The instrument assigns one point "for each indication of participation in sexuality education venue" (Harris & Hays, p. 243). The instrument consists of 12 items; seven focused on education and five focused on supervision. Higher scores indicate significant experience levels in discussing sexual topics with clients. I

used this scale to measure the marriage and family therapists' sexual educational background and supervision experience.

The Clinical Experience Scale is an instrument comprised of five items with a multiple-choice format, and "…higher scores indicate more clinical experience" (Harris & Hays, 2008, p. 243). An example item is "Clinical experience with sexual issues" with a multiple-choice answer portion with answer options such as "I have clinical experience with only one or two cases involving sexuality issues." I used this scale to measure marriage and family therapists' clinical experience. The last scale from Harris and Hays (2008) is the Sexuality Discussion with Clients Scale. This scale is comprised of nine items that measure on a 7-point Likert-type scale. A higher score indicates that a marriage and family therapist has an increased willingness to initiate a sexual discussion with a client. I used this scale to measure marriage and family therapists' willingness to discuss sexual issues with clients. I examined the independent variables of sex, age, strength of religion, sexual orientation, practice experience, practice setting, graduate specialization, and relationship status using the Demographic Data instrument (see Cupit, 2010).

Data Analysis Plan

The data analysis software I employed in this research was SPSS 24.0. I ran a frequency analysis to ensure I had correctly entered the data and there were no missing values due to answers omitted by participants. I also eliminated missing data as needed. Thereafter, I analyzed the data using a similar approach to that of Harris and Hays (2008) and Cupit (2010), which included using "descriptive statistics, correlation, comparative, and multiple regression analysis using stepwise linear regression" (see Cupit, p. 76). I

used stepwise linear regression to determine which of the following independent variables, attitudes, knowledge, training, supervision experience, and clinical experience, or which combination of those independent variables, attitudes, knowledge, training, supervision experience, and clinical experience, had the greatest statistical significance when acting upon the dependent variable of a therapist's comfort level with sexuality. The BSAS measured the independent variables for attitudes, the Miller-Fisk Sexual Knowledge Questionnaire for knowledge, sexuality education and Supervision Scale for training and supervision, and the Clinical Experience Scale for clinical experience. The variables of attitudes and knowledge were ordinal because I measured them on a 7-point Likert-type scales. The variables of training, supervision experience, and clinical experience were nominal because I measured them by items that if checked, increased the score, i.e., the more items checked, the higher the score. I measured the dependent variable of the therapist's comfort level with sexuality by using the Sexual Comfort Scale, which is also a 7-point Likert-type scale; the variable was ordinal.

I also used stepwise linear regression to determine which independent variables (attitudes, knowledge, training, supervision experience, and clinical experience) or which combination of independent variables (attitudes, knowledge, training, supervision experience, and clinical experience) had the greatest statistical significance when acting upon the dependent variable of a therapist's willingness to discuss sexual topics with clients. The BSAS measured the independent variables for attitudes, the Miller-Fisk Sexual Knowledge Questionnaire for Knowledge, Sexuality Education and Supervision Scale for training and supervision, and the Clinical Experience Scale for clinical

experience; the variables of attitudes and knowledge were ordinal because I measured them on 7-point Likert-type scales. The variables of training, supervision experience, and clinical experience were nominal since I measured them by items that, if checked, increased the score, i.e., the more items checked, the higher the score. The Sexuality Discussion measured the dependent variable of the therapist's willingness to discuss sexual topics with the Sexuality Discussion with Clients Scale; this scale is also a 7-point Likert-type scale, and the variable was ordinal. Stepwise linear regression was an appropriate statistical test and provided a statistical analysis method wherein I used both nominal and ordinal variables in the same test to analyze their impact on the dependent variable.

Research Questions and Hypotheses

I used the following research questions (RQs) and hypotheses to guide the study:

RQ1: What is the relationship between attitudes, knowledge, training, supervision experience, and clinical experience and a therapist's willingness to discuss sexual topics with clients?

$H_0$1: There is no statistically significant relationship between attitudes, knowledge, training, supervision experience, and clinical experience and a therapist's willingness to discuss sexual topics with clients.

H_a1: There is a statistically significant relationship between attitudes, knowledge, training, supervision experience, and clinical experience and a therapist's willingness to discuss sexual topics with clients.

RQ2: What is the relationship between attitudes, knowledge, training, supervision experience, and clinical experience and a therapist's comfort discussing sexual topics with clients?

$H_0$2: There is no statistically significant relationship between attitudes, knowledge, training, supervision experience, and clinical experience and a therapist's comfort discussing sexual topics with clients.

H_a2: There is a statistically significant relationship between attitudes, knowledge, training, supervision experience, and clinical experience and a therapist's comfort discussing sexual topics with clients.

RQ3: What independent variables (attitudes, knowledge, training, supervision experience, and clinical experience) predict a therapist's comfort level with sexuality?

$H_0$3: There is no statistically significant predictive relationship between the independent variables (attitudes, knowledge, training, supervision experience, and clinical experience) and a therapist's comfort level with sexuality.

H_a3: There is a statistically significant predictive relationship between the independent variables (attitudes, knowledge, training, supervision experience, and clinical experience) and a therapist's comfort level with sexuality.

RQ4: What independent variables (attitudes, knowledge, training, supervision experience, and clinical experience) predict a therapist's willingness to discuss sexual topics with clients?

$H_0$4: There is no statistically significant predictive relationship between the independent variables (attitudes, knowledge, training, supervision experience, and clinical experience) and a therapist's willingness to discuss sexual topics with clients.

H_a4: There is a statistically significant predictive relationship between the independent variables (attitudes, knowledge, training, supervision experience, and clinical experience) and a therapist's willingness to discuss sexual topics with clients.

RQ5: What is the relationship between the independent variables of a therapist's age, sex, sexual orientation, number of years in practice, type of graduate program, relationship status, practice setting, or strength of religion and the dependent variable of the sexual comfort of a therapist?

$H_0$5: There is no statistically significant relationship between the independent variables of a therapist's age, sex, sexual orientation, number of years in practice, type of graduate program, relationship status, practice setting, or strength of religion and the dependent variable of the sexual comfort of a therapist.

H_a5: There is a statistically significant relationship between the independent variables of a therapist's age, sex, sexual orientation, number of years in practice, type of graduate program, relationship status, practice setting, or strength of religion and the dependent variable of the sexual comfort of a therapist.

RQ6: What is the relationship between the independent variables of a therapist's age, sex, sexual orientation, number of years in practice, type of graduate program, relationship status, practice setting, or strength of religion and the dependent variable of a therapist's willingness to discuss sexual topics?

$H_0$6: There is no statistically significant relationship between the independent variables of a therapist's age, sex, sexual orientation, number of years in practice, type of graduate program, relationship status, practice setting, or strength of religion and the dependent variable of a therapist's willingness to discuss sexual topics?

H_a6: There is a statistically significant relationship between the independent variables of a therapist's age, sex, sexual orientation, number of years in practice, type of graduate program, relationship status, practice setting, or strength of religion and the dependent variable of a therapist's willingness to discuss sexual topics.

Data Analysis for Hypothesis 1: A Pearson-product moment correlation will be conducted for each independent variable.

Data Analysis for Hypothesis 2: A Pearson-product moment correlation will be conducted for each independent variable.

Data Analysis for Hypothesis 3: A stepwise linear regression will be conducted to determine whether one or more of the variables can adequately predict a therapist's sexual comfort when discussing sexual topics.

Data Analysis for Hypothesis 4: A stepwise linear regression will be conducted to determine whether one or more of the variables can adequately predict a therapist's willingness to discuss sexual topics with clients.

Data Analysis for Hypothesis 5: A Pearson-product moment correlation will be conducted for each independent variable, those being therapist's age, sex, sexual orientation, number of years in practice, type of graduate program, relationship status, practice setting, and strength of religion, and a Chi-square measure of assessment will be

used to determine the scores compared with the dependent variable of a therapist's sexual comfort.

Data Analysis for Hypothesis 6: A Pearson-product moment correlation will be conducted for each independent variable, those being therapist's age, sex, sexual orientation, number of years in practice, type of graduate program, relationship status, practice setting, and strength of religion, and a Chi-square measure of assessment will be used to determine the scores compared with the dependent variable of a therapist's willingness to discuss sexual topics with a client.

I used correlation, descriptive statistics, comparative, and multiple regression analysis using stepwise linear regression. Stepwise linear regression allowed me to sort through each independent variable to determine which independent variable or which combination of independent variables had the greatest statistical significance when acting upon the dependent variable.

Threats to External and Internal Validity

Campbell and Stanley (1966) identified four threats to external validity: interaction between the test subjects and the treatment, pretesting, setting interaction issues, and multiple treatments causing issues. Creswell (2009) identified three types of threats to external validity: interaction of selection and treatment, the interaction of setting and treatment, and interaction of history and treatment. Randomization was the best measure to ensure external validity: I used randomization in this study, therefore, external validity was high (see Campbell & Stanley, 1966).

Threats to internal validity were history, maturation, regression, selection, mortality, diffusion of treatment, compensation/resentful demoralization, compensatory rivalry, testing, and instrumentation (see Creswell, 2009). As this study used a correlational research design using a randomized sample, history maturation, regression, and selection did not pose a threat to internal validity. Mortality posed a small but unlikely threat given that most participants finished their surveys once started and diffusion of treatment was not applicable to this study nor was compensatory/resentful demoralization or compensatory rivalry. Testing was not an issue because this was only a one-time questionnaire and instrumentation did not change (see Creswell, 2009).

Threats to Statistical Validity

To perform a linear regression test correctly, several assumptions were met to provide accurate forecasts, confidence intervals, and insights. If these assumptions had not been met, then the forecasts, confidence intervals, and insights might have been misleading or biased. The assumptions underlying a multiple linear regression were the following: normality, homoscedasticity, linearity, independence of observations, no multicollinearity, and no significant outliers.

Normality

To ensure that normality was present, the residuals (errors) needed to be approximately and normally distributed. Two common ways to check this were a histogram and a normal P-P Plot or a normal Q-Q Plot of the residuals (see Green & Salkind, 2014).

Homoscedasticity

The data needed to demonstrate that there was homoscedasticity present (i.e., the variances along the line of best fit remain similar when examined through plotting) (see Green & Salkind, 2014). I avoided heteroscedasticity and examined it by plotting a graph with the data to determine whether or not homoscedasticity was present. If it was, then homoscedasticity was present, and the assumption had been met (see Field, 2013)

Independence of Observations

Field (2013) stated independence of observations could be checked by using the Durbin-Watson statistical test for serial correlations between errors in regression models. "Specifically, it tests whether adjacent residuals are correlated" (p. 874) to determine the assumption of independence of errors, with a test that varies between 0 and 4. A value of 2 indicates the residuals are uncorrelated. A value above 2 indicates a negative correlation, and a value below 2 indicates a positive correlation. If the value is below 1 or above 3, there is cause for concern.

Linearity

The outcome variable should linearly relate to any predictor variable. This assumption can be tested by plotting the points on a graph. There should be symmetrical distribution along a diagonal line in the graph indicating that there is a linear relationship. However, a bowed or other strange pattern on the graph is indicative of errors (see Field, 2013).

Multicollinearity

Field (2013) noted that multicollinearity exists when two or more independent variables are "closely linearly related" (p. 879), making it difficult to understand which variable has contributed to the variance in the dependent variable. As collinearity increases, standard errors increase as well. Also, it limits the size of *R*. SPSS provides collinearity diagnostic tests, such as the variance of inflation factor (VIF) to indicate whether an independent variable has a strong linear relationship with another independent variable. According to Bowerman and O'Connell (as cited in Field, 2013), "if the largest VIF is greater than ten then there is cause for concern. If the average VIF is substantially greater than one, then the regression may be biased" (Field, 2013, p. 325). Similarly, Menard (determined that a "tolerance below 0.1 indicates a serious problem [and] tolerance below 0.2 indicates a potential problem (as cited in Field, 2013, p. 325).

Outliers

Outliers are observations that are significantly different from the majority and lead to standard errors and bias (Field, 2013). SPSS provides statistical tests to ascertain if outliers exist in data, including the use of a histogram. SPSS also provides a test for multivariate outliers called the Mahalanobis distance test. For example, if a study with three predictors, where $N = 100$, achieves a value of 15 or more, it would be problematic and would indicate that an outlier is present in the dataset and will require removal before running a regression analysis (Field, 2013).

Ethical Procedures

The participants in this study were volunteers who completed an informed consent package at the beginning of the survey to ensure they understood the following: their answers would be confidential, their participation was voluntary, and they could stop at any time they were uncomfortable or otherwise wanted to stop. I delivered the informed consent package electronically as the initial portion of the survey. Once completed, the participants then continued to begin the survey. I informed the prospective survey participants that by completing the survey, they were acknowledging the potential risks and understood them. Also, they acknowledged they understood their answers were being submitted anonymously and that by completing the survey they had given their implied informed consent. If a participant failed to complete the survey, I discarded the survey. If I did not reach the necessary number of participants, then I would randomly choose another set of prospective participants and would email them an informed consent form and the survey link until I reached the requisite number of survey responses.

In the cover letter that accompanied the survey, bold black letters advised the prospective participants that their involvement was voluntary. Participants' answers were anonymous, so there was limited risk to participants' confidentiality. I also advised them not to indicate their identity anywhere in the survey questionnaire.

I conducted this study according to Walden University's Institutional Review Board's requirements relating to human subjects, including ensuring that the participants' identities remained confidential and that their answers remained anonymous and untraceable to the participant. I acquired formal permission from Walden University's

IRB before the commencement of the research process with the formal approval issued under number 07-21-17-0316271.

Summary

In Chapter 3, I outlined the quantitative cross-sectional correlational research design, the justification for using this design, and the methods that I used to acquire participant data using Survey Monkey. I also presented descriptions of the participant sample, eligibility requirements, and the sampling procedures that I used. Participants provided their informed consent, then answered questions from several instruments. Next, I analyzed the data to determine if there was any statistically significant correlational links between the variables in the study. I presented the steps I took to ensure the ethical standards related to human subjects as defined by Walden University. Finally, I discussed internal, external, and statistical validity.

Chapter 4: Results

The primary purpose of this study was to examine the relationships between the independent variables of therapists' attitudes and knowledge and the dependent variables of therapists' comfort with sexual topics and willingness to discuss sexual topics. A secondary purpose of this study was to examine the relationships between the independent variables of personal characteristics of therapists and the dependent variables of therapists' comfort with sexual topics and willingness to discuss sexual topics. A better understanding of the relationships between these variables in the context of Bowenian theory provided a significant addition to the body of research in this area.

Research Questions and Hypothesis Testing

I used six research questions and related hypotheses to guide the study:

RQ1: What is the relationship between attitudes, knowledge, training, supervision experience, and clinical experience and a therapist's willingness to discuss sexual topics with clients?

$H_0$1: There is no statistically significant relationship between attitudes, knowledge, training, supervision experience, and clinical experience and a therapist's willingness to discuss sexual topics with clients.

H_a1: There is a statistically significant relationship between attitudes, knowledge, training, supervision experience, and clinical experience and a therapist's willingness to discuss sexual topics with clients.

RQ2: What is the relationship between attitudes, knowledge, training, supervision experience, and clinical experience and a therapist's comfort discussing sexual topics with clients?

$H_0$2: There is no statistically significant relationship between attitudes, knowledge, training, supervision experience, and clinical experience and a therapist's comfort discussing sexual topics with clients.

H_a2: There is a statistically significant relationship between attitudes, knowledge, training, supervision experience, and clinical experience and a therapist's comfort discussing sexual topics with clients.

RQ3: What independent variables (attitudes, knowledge, training, supervision experience, and clinical experience) predict a therapist's comfort level with sexuality?

$H_0$3: There is no statistically significant predictive relationship between the independent variables (attitudes, knowledge, training, supervision experience, and clinical experience) and a therapist's comfort level with sexuality.

H_a3: There is a statistically significant predictive relationship between the independent variables (attitudes, knowledge, training, supervision experience, and clinical experience) and a therapist's comfort level with sexuality.

RQ4: What independent variables (attitudes, knowledge, training, supervision experience, and clinical experience) predict a therapist's willingness to discuss sexual topics with clients?

$H_0$4: There is no statistically significant predictive relationship between the independent variables (attitudes, knowledge, training, supervision experience, and clinical experience) and a therapist's willingness to discuss sexual topics with clients.

H_a4: There is a statistically significant predictive relationship between the independent variables (attitudes, knowledge, training, supervision experience, and clinical experience) and a therapist's willingness to discuss sexual topics with clients.

RQ5: What is the relationship between the independent variables of a therapist's age, sex, sexual orientation, number of years in practice, type of graduate program, relationship status, practice setting, or strength of religion and the dependent variable of the sexual comfort of a therapist?

$H_0$5: There is no statistically significant relationship between the independent variables of a therapist's age, sex, sexual orientation, number of years in practice, type of graduate program, relationship status, practice setting, or strength of religion and the dependent variable of the sexual comfort of a therapist.

H_a5: There is a statistically significant relationship between the independent variables of a therapist's age, sex, sexual orientation, number of years in practice, type of graduate program, relationship status, practice setting, or strength of religion and the dependent variable of the sexual comfort of a therapist.

RQ6: What is the relationship between the independent variables of a therapist's age, sex, sexual orientation, number of years in practice, type of graduate program, relationship status, practice setting, or strength of religion and the dependent variable of a therapist's willingness to discuss sexual topics?

$H_0$6: There is no statistically significant relationship between the independent variables of a therapist's age, sex, sexual orientation, number of years in practice, type of graduate program, relationship status, practice setting, or strength of religion and the dependent variable of a therapist's willingness to discuss sexual topics.

H_a6: There is a statistically significant relationship between the independent variables of a therapist's age, sex, sexual orientation, number of years in practice, type of graduate program, relationship status, practice setting, or strength of religion and the dependent variable of a therapist's willingness to discuss sexual topics.

I used eight survey instruments in this study. Cupit (2010) originally used the demographic questions when studying "counselors, who were members of the American Counseling Association" (p. 13). The independent variables measured by the demographic questions were sex, age, strength of religion, sexual orientation, practice experience, practice setting, and graduate specialization.

I measured sexual knowledge using the 24-Item Miller Fisk Sexual Knowledge Questionnaire. Harris and Hays (2008) developed the Sexual Comfort Scale using a 7-point Likert-type scale (1 = *uncomfortable*; 7 = *comfortable*) to measure how comfortable the therapist would be discussing specific sexual topics with clients. Hendrick et al. (2006) developed the BSAS, which was an update to the authors' previous scale, the SAS. The BSAS was appropriate for this study because several researchers used it to measure the sexual comfort of mental health professionals (see Cupit, 2010; Hanzlik & Gaubatz, 2012). Harris and Hays (2008) developed the Sexuality Education Scale, which consists of seven items. Harris and Hays and Cupit (2010) used this scale in their research

with marriage and family therapists and counselors incorporating the variables in the current study. The authors also developed the Experience in Supervision Scale to measure the number of interactions therapists had while being supervised that involved discussions of sexuality. Harris and Hays created the Clinical Experience Scale to assess the aggregate experience therapists had in clinical settings discussing sexual issues. The final instrument used in the study was the Sexuality Discussion with Clients Scale, which Harris and Hays developed to assess the willingness of therapists to engage in discussions with clients about sexual topics.

Chapter 4 is organized by a description of the sample, reliability analysis, descriptive statistics, data screening, research question and hypothesis testing, and conclusions. After data collection, I exported the data from Survey Monkey to SPSS 24 for analysis. The following sections provide a description of the data collection process and participant demographics.

Data Collection

After I obtained the required approval from the Walden IRB and the publishers, I converted the instruments to an online format for electronic distribution through Survey Monkey, an online data collection tool. I selected participants from a list of licensed marriage and family therapists practicing in the United States, who possessed a master's or doctoral degree, and who were active in their profession. This list was available for purchase online. Thereafter, I sent an e-mail explaining the study to 20,000 potential participants soliciting their participation. I collected data from October 26, 2017 to November 20, 2017. I had determined that the sample size necessary to meet the effect,

power, and alpha for this study was 107 based on a high power of 0.95, a medium effect size equal to $f^2 = 0.15$, and a significance level of 0.5. I administered 133 surveys, and 90 participants completed them. Thereafter, I performed a post hoc power analysis with a medium effect size equal to $f^2 = 0.2$, and a significance level of .5 with five predictors and a sample size of 90, which yielded .90 power. This study had a 90% power to detect statistically significant associations between the independent and dependent variables using stepwise linear regression.

I had planned a sampling frame of 2,000 prospective participants, but increased the sampling frame to 20,000 to achieve the necessary sample size. I had intended to use chi-square to analyze Hypotheses 5 and 6. However, because the chi-square test returned too many invalid *p* values due to over 20% of the cells in the tables being a 0 value, I substituted the Fisher's exact test because it also is a test for independence and works well with smaller sample sizes. This change was successful, and I found statistically significant results using this method of analysis. There was one change in instrumentation: I omitted a demographic item about relationship status. This oversight did not render the results inaccurate but did suggest an item for future research.

Description of Sample

The sample consisted of 90 licensed marriage and family therapists (LMFT). Of this sample, 81.1% ($n = 73$) were female and 18.9% ($n = 17$) were male. I asked the participants to rate the strength of their religion on a scale of 1 = *weak* to 5 = *strong*. LMFTs had a moderate degree of religious strength ($M = 3.37$, $SD = 1.51$) as measured by Cupit's (2010) Demographic Data Survey. Participants' ages ranged from 32 to 78 (*M*

= 56.92, *SD* = 12.50), and they had been in practice two to 50 years (*M* = 21.33, *SD* = 11.70). Regarding practice setting, most participants (70%) were in private practice; 16.7% (*n* = 15) were in agency settings; and 7.8% (*n* = 7) were in other settings. Practice setting data are presented in Table 1.

Table 1

Practice Setting

Setting	*n*	%
Agency	15	16.7
Hospital	3	3.3
Private practice	63	70.0
School	2	2.2
Other	7	7.8
Total	90	100.0

Regarding graduate specialization, most respondents' (78.9%, *n* = 71) graduate specializations were in marriage, couples, and family. The second most frequent graduate specialization was clinical mental health and community counseling (8.9%, *n* = 8). Career counseling had the least number (2.2%, *n* = 2) of graduate specializations (see Table 2).

Table 2

Graduate Specialization

Specialization	*n*	%
Addiction	3	3.3
Career	2	2.2
Clinical mental health/community counseling	8	8.9
Marriage, couple, and family	71	78.9
Other	6	6.7
Total	90	100.0

Regarding sexual orientation, most therapists (86.7%, *n* = 78) were heterosexual; 7.8% (*n* = 7) were bisexual; 4.4% (*n* = 4) were homosexual; and 1.1% (*n* = 1) reported "other." The sample was representative of the LMFT profession, as currently 11,350 LMFTs are in private practice (see U.S. Department of Labor, Bureau of Labor Statistics, 2016). Additionally, the sample was reflective because the necessary sample size using probability sampling techniques was 89, and there were 90 participants.

Instrument Reliability for Sample

I assessed instrument reliability of the sample with Cronbach's alpha if there was published reliability for the instrument or variable. In order of variables tested, the results for sexual knowledge were α = .43; for sexual comfort, the results were α = .86. The reliability for sexual attitudes indicated that the internal consistency ranged from .71 for communion to .82 for permissiveness. Willingness to discuss sexual topics had a score of α = .80, and the score for comfort discussing sexual topics was α = .86. Reliability coefficients are presented in Table 3.

Table 3

Reliability Coefficients for Sample

Variable	*N* of items	Cronbach's alpha
Sexual knowledge	24	.431
Sexual attitudes		
Permissiveness	10	.825
Communion	5	.712
Instrumentality	5	.747
Willingness to discuss sexual topics	9	.802
Comfort discussing sexual topics	15	.862

Descriptive Statistics

For sexual knowledge on the Miller Fisk Sexual Knowledge Questionnaire, scores ranged from 6 to 22 ($M = 17.36$, $SD = 2.56$). For sexual attitudes (permissiveness), scores ranged from 1.60 to 5.00 ($M = 3.36$, $SD = 0.78$). For sexual attitudes (communion), scores ranged from 1.00 to 4.20 ($M = 2.49$, $SD = 0.74$). For sexual attitudes (instrumentality), scores ranged from 2.00 to 5.00 ($M = 3.61$, $SD = 0.75$). Descriptive statistics for the variables of interest are presented in Table 4.

Table 4

Descriptive Statistics

Variable	Minimum	Maximum	*M*	*SD*
Age	32	78	56.92	12.50
Years in practice	2	50	21.33	11.70
Sexual knowledge	6.00	22.00	17.36	2.56
Sexual attitudes (permissiveness)	1.60	5.00	3.36	0.78
Sexual attitudes (communion)	1.00	4.20	2.49	0.74
Sexual attitudes (instrumentality)	2.00	5.00	3.61	0.75
Graduate sexuality training	.00	6.00	2.09	1.25
Supervision experience	.00	4.00	1.13	0.72
Clinical experience	.00	3.00	1.10	0.37
Willingness to discuss sexual topics	1.67	6.33	4.46	1.04
Comfort discussing sexual topics	3.47	6.93	6.02	0.72

I screened the data for normality with skewness and kurtosis statistics. In SPSS, distributions are considered normal if their absolute values are less than two times their standard errors. Normal distribution was based on these criteria: age, years in practice, permissiveness, communion, instrumentality, and willingness to discuss sexual topics. However, sexual knowledge, graduate sexuality training, supervision experience, clinical experience, and comfort discussing sexual topics were not normally distributed. Nevertheless, to preserve the nature of the data, I made no attempt to remediate the skewed distributions. Skewness and kurtosis coefficients are presented in Table 5.

Table 5

Skewness and Kurtosis Coefficients

	Skewness		Kurtosis	
Variable	Statistic	Std. error	Statistic	Std. error
Age	-.448	.254	-.984	.503
Years in practice	.401	.254	-.727	.503
Sexual knowledge	-1.21	.254	3.57	.503
Sexual attitudes (permissiveness)	-.068	.254	-.669	.503
Sexual attitudes (communion)	.195	.254	-.402	.503
Sexual attitudes (instrumentality)	.205	.254	-.477	.503
Graduate sexuality training	.603	.254	.080	.503
Supervision experience	.892	.254	2.35	.503
Clinical experience	2.59	.254	9.74	.503
Willingness to discuss sexual topics	-.170	.254	-.229	.503
Comfort discussing sexual topics	-1.33	.254	2.10	.503

Research Question 1, Hypothesis 1

What is the relationship between attitudes, knowledge, training, supervision experience, and clinical experience and a therapist's willingness to discuss sexual topics with clients? I investigated Research Question 1, Hypothesis 1 with the Pearson's *r*. The independent variables were attitudes, knowledge, training, supervision experience, and clinical experience. The dependent variable was a therapist's willingness to discuss sexual topics with clients. Table 6 provides the bivariate correlation results.

Table 6

Research Question 1 Correlation Results

Variable	Pearson's *r*	*p*
Sexual attitudes (permissiveness)	-.12	.248
Sexual attitudes (communion)	.02	.819
Sexual attitudes (instrumentality)	-.14	.189
Sexual knowledge	-.07	.492
Graduate sexuality training	.31	.003**
Supervision experience	.32	.002**
Clinical experience	.32	.002**

Note. **$p < .01$; Dependent variable = Willingness to discuss sexual topics. $N = 90$, two-tailed.

There was no significant relationship between sexual attitudes (permissiveness) and a therapist's willingness to discuss sexual topics, $r(88) = -.12$, $p = .248$, two-tailed. There was no significant relationship between sexual attitudes (communion) and a therapist's willingness to discuss sexual topics, $r(88) = .02$, $p = .819$, two-tailed. There was no significant relationship between sexual attitudes (instrumentality) and a therapist's willingness to discuss sexual topics, $r(88) = -.14$, $p = .189$, two-tailed. There was no significant relationship between sexual knowledge and a therapist's willingness to discuss sexual topics, $r(88) = -.07$, $p = .492$, two-tailed. There was a significant, positive relationship between graduate sexuality training and a therapist's willingness to discuss sexual topics, $r(88) = .31$, $p = .003$, two-tailed. As graduate sexuality training increased, there was a corresponding increase in a therapist's willingness to discuss sexual topics. The coefficient of determination was (r^2) = .0961, which means that graduate sexuality

training can explain 9.61% of the variance in a therapist's willingness to discuss sexual topics. A scatter plot of this relationship is illustrated in Figure 1.

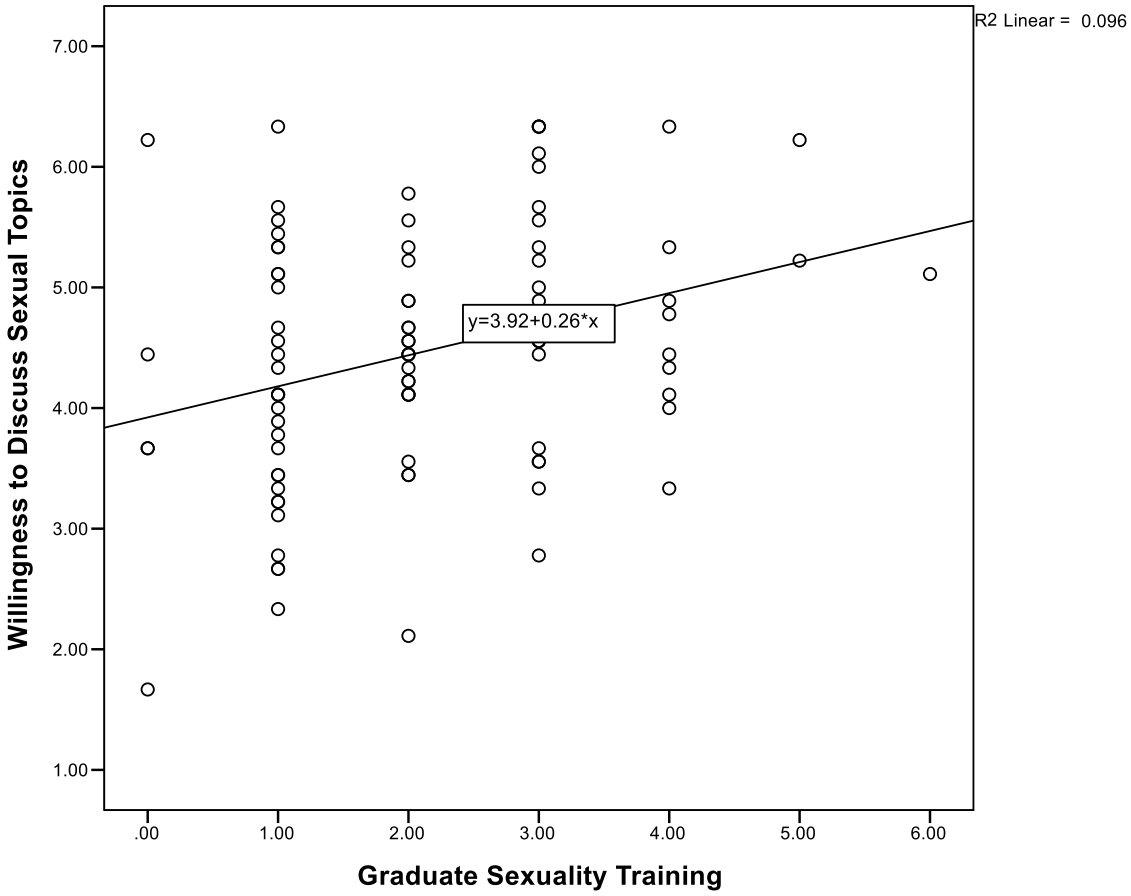

Figure 1. Graduate sexuality training and willingness to discuss sexual topics.

There was a significant, positive relationship between supervision experience and a therapist's willingness to discuss sexual topics, $r(88) = .32$, $p = .002$, two-tailed. As supervision experience increased, there was a corresponding increase in a therapist's willingness to discuss sexual topics. The coefficient of determination was (r^2) = .1024, which means that the supervision experience can explain 10.24% of the overall variance

in a therapist's willingness to discuss sexual topics with clients. A scatter plot of this relationship is illustrated in Figure 2.

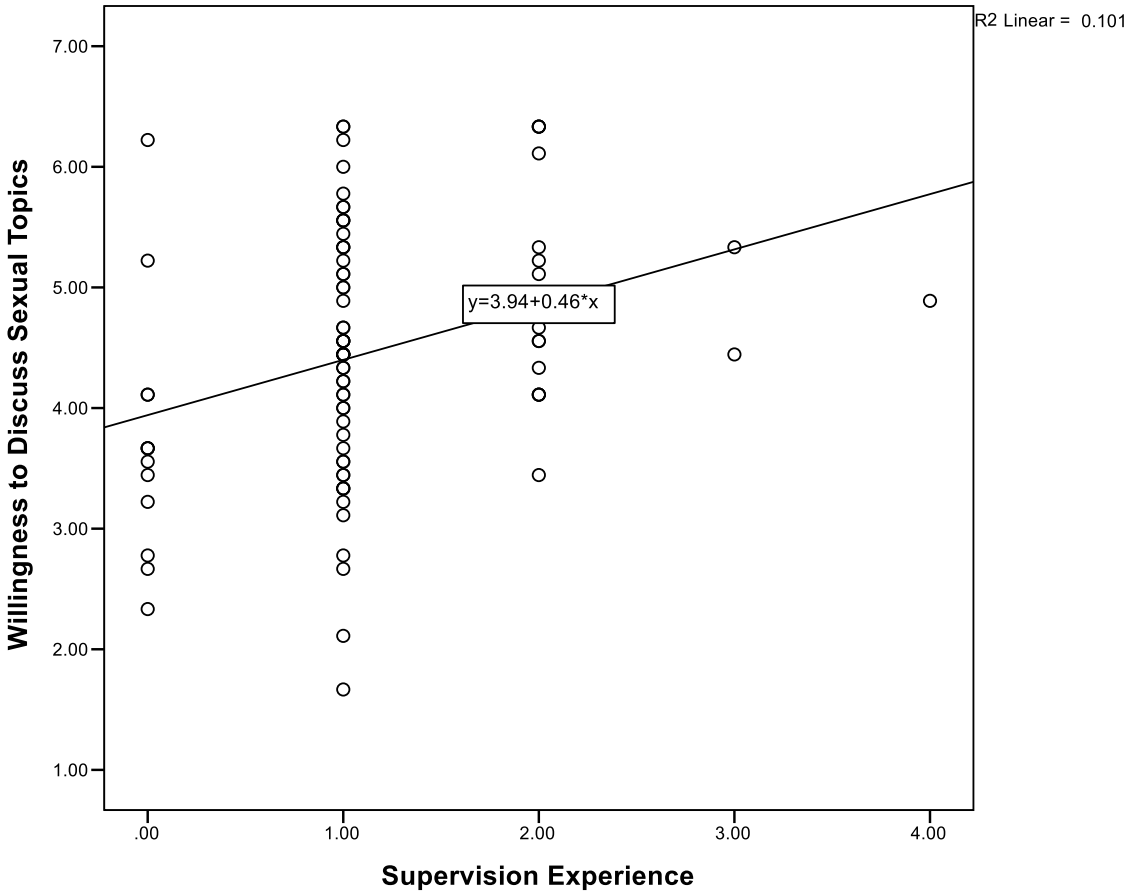

Figure 2. Supervision experience and willingness to discuss sexual topics.

There was a significant, positive relationship between clinical experience and a therapist's willingness to discuss sexual topics, $r(88) = .32$, $p = .002$, two-tailed. As clinical experience increased, there was a corresponding increase in a therapist's willingness to discuss sexual topics. The coefficient of determination was (r^2) = .1024, which means that clinical experience can explain 10.24% of the variance in a therapist's willingness to discuss sexual topics.

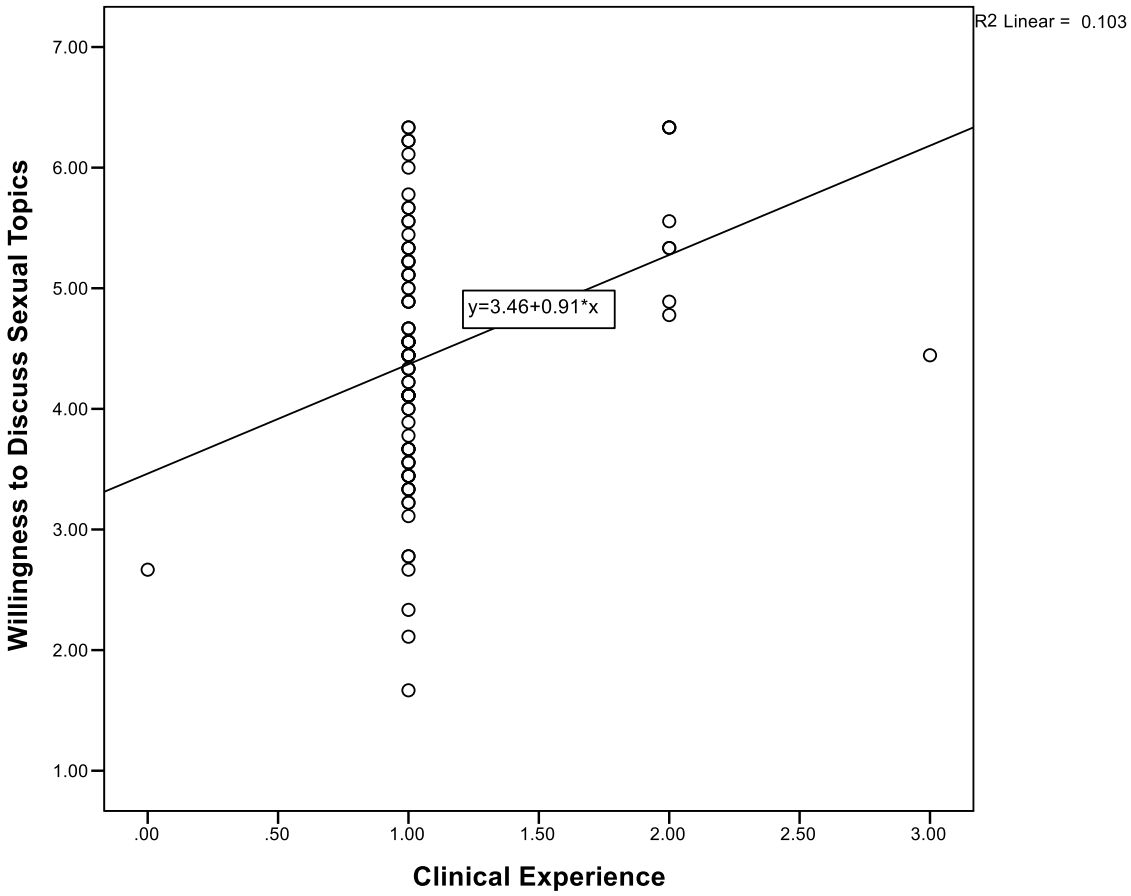

Figure 3. Clinical experience and willingness to discuss sexual topics.

H_{01} stated there is no statistically significant relationship between the independent variables (attitudes, knowledge, training, supervision experience, and clinical experience) and the therapists' willingness to discuss sexual topics with clients. I observed significance in three out of seven bivariate relationships examined. Therefore, the null hypothesis was partially rejected.

Research Question 2, Hypothesis 2

What is the relationship between attitudes, knowledge, training, supervision experience, and clinical experience and a therapist's comfort discussing sexual topics

with clients? I investigated Research Question 2, Hypothesis 2 with the Pearson's *r*. The independent variables were attitudes, knowledge, training, supervision experience, and clinical experience. The dependent variable was a therapist's comfort discussing sexual topics with clients. Table 7 provides the bivariate correlation results.

Table 7

Research Question 2 Correlation Results

Variable	Pearson's *r*	*p*
Sexual attitudes (permissiveness)	-.19	.079
Sexual attitudes (communion)	.04	.731
Sexual attitudes (instrumentality)	.10	.374
Sexual knowledge	.08	.462
Graduate sexuality training	.19	.078
Supervision experience	.11	.324
Clinical experience	.01	.931

Note. Dependent variable = Comfort discussing sexual topics. $N = 90$, two-tailed.

There was no significant relationship between sexual attitudes (permissiveness) and a therapist's comfort discussing sexual topics, $r(88) = -.19$, $p = .079$, two-tailed. There was no significant relationship between sexual attitudes (communion) and a therapist's comfort discussing sexual topics, $r(88) = .04$, $p = .731$, two-tailed. There was no significant relationship between sexual attitudes (instrumentality) and a therapist's comfort discussing sexual topics, $r(88) = .10$, $p = .374$, two-tailed. There was no significant relationship between sexual knowledge and a therapist's comfort discussing sexual topics, $r(88) = .08$, $p = .462$, two-tailed. There was no significant relationship between graduate sexuality training and a therapist's comfort discussing sexual topics,

$r(88) = .19$, $p = .078$, two-tailed. There was no significant relationship between supervision experience and a therapist's comfort discussing sexual topics, $r(88) = .11$, $p = .324$, two-tailed. There was no significant relationship between clinical experience and a therapist's comfort discussing sexual topics, $r(88) = .01$, $p = .931$, two-tailed.

H_{02} stated that there is no statistically significant relationship between the independent variables (attitudes, knowledge, training, supervision experience, and clinical experience) and a therapist's comfort discussing sexual topics with clients. I observed no significant relationships between the independent variables (attitudes, knowledge, training, supervision experience, and clinical experience) and the therapists' comfort discussing sexual topics with clients. Significance values ranged from $p = .078$ to $p = .931$. Therefore, the null hypothesis was accepted.

Research Question 3, Hypothesis 3

What independent variables (attitudes, knowledge, training, supervision experience, and clinical experience) predict a therapist's comfort level with sexuality? I tested Research Question 3, Hypothesis 3 with stepwise multiple linear regression. The independent variables were attitudes, knowledge, training, supervision experience, and clinical experience. The dependent variable was a therapist's comfort level with sexuality. I entered no variables into the equation as determined by SPSS. When using stepwise multiple linear regression, if none of the independent variables are significantly related to the outcome variable, no model is generated.

H_{03} stated that there is no statistically significant predictive relationship between the independent variables (attitudes, knowledge, training, supervision experience, and

clinical experience) and a therapist's comfort level with sexuality. Since this SPSS analysis generated no regression model, there was no statistically significant predictive relationship between the independent variables (attitudes, knowledge, training, supervision experience, and clinical experience) and a therapist's comfort level with sexuality. Therefore, the null hypothesis was accepted.

Research Question 4, Hypothesis 4

What independent variables (attitudes, knowledge, training, supervision experience, and clinical experience) predict a therapist's willingness to discuss sexual topics with clients? I investigated Research Question 4, Hypothesis 4 with stepwise multiple linear regression. The independent variables were sexual attitudes, knowledge, training, supervision experience, and clinical experience. The dependent variable was the therapists' willingness to discuss sexual topics with clients.

During the analysis, I also examined the residuals. A residual is the difference between the observed and the predicted values of the dependent variable. Standardized residuals greater than ±3 are candidates for exclusion. Standardized residuals ranged from -2.79 to 2.39 and were, therefore, within normal limits. A normal P-P Plot was also generated to illustrate that the residuals were normally distributed. A normal distribution is evidenced by the proximity of the plotted values for the residuals along the 45-degree line in Figure 4.

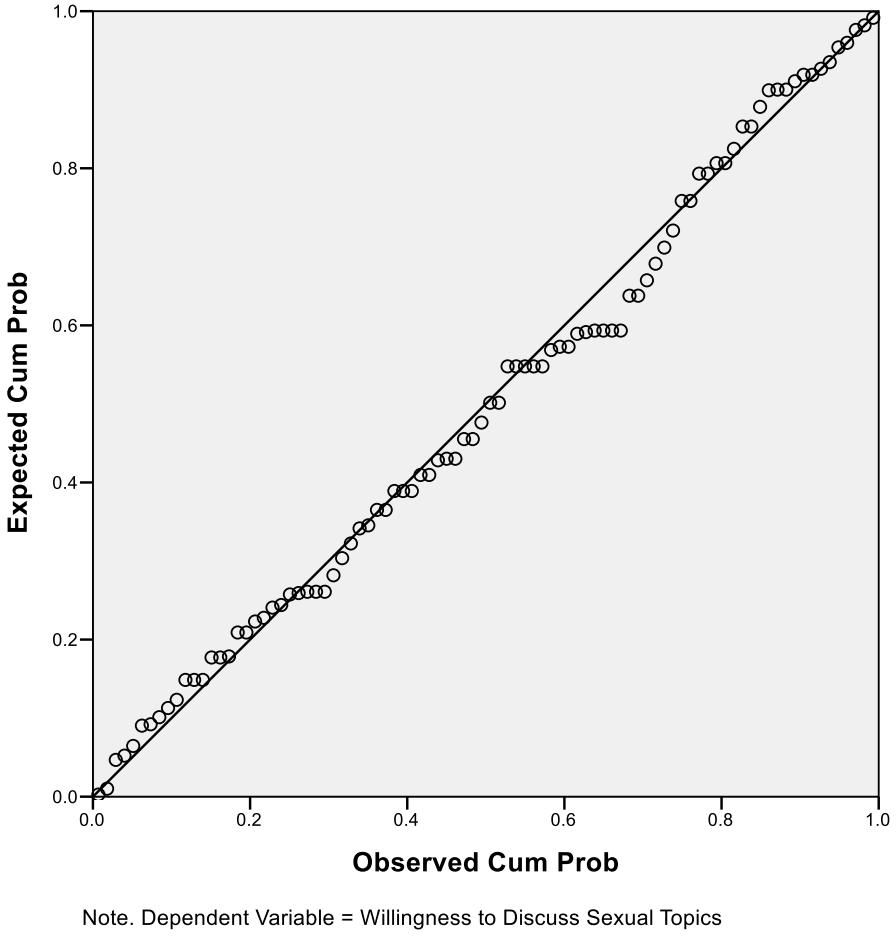

Figure 4. Normal P-P plot for regression standardized residuals.

The independence of the error terms was examined with a scatter plot of the regression standardized residuals by the standardized predicted values. Independence of the error terms is illustrated by a relatively random pattern of points along the horizontal line (See Figure 5).

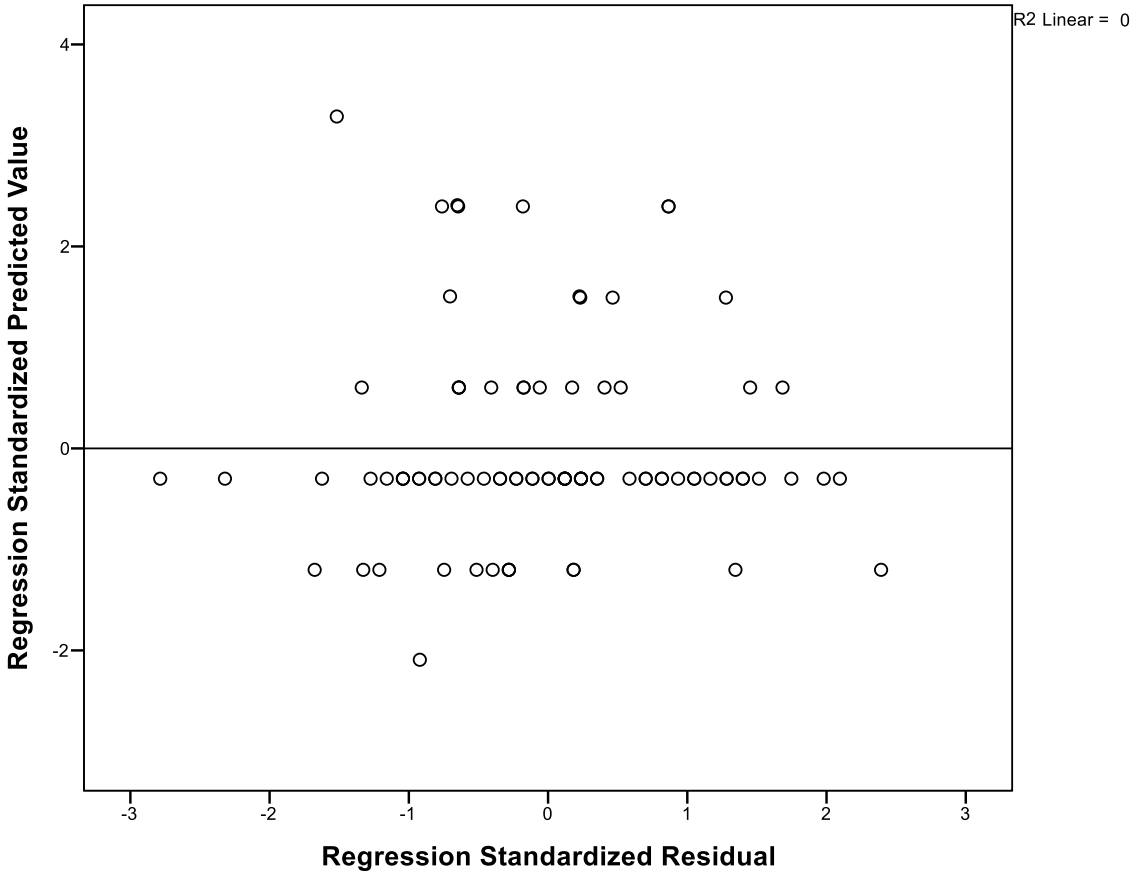

Figure 5. Scatterplot of standardized residuals by standardized predicted values.

A regression model was generated from the stepwise procedure, $F(2, 87) = 9.28$, $p < .001$; $R^2 = .18$. Examination of the univariate statistics included in the model revealed that clinical experience ($\beta = 0.27$, $t = 2.81$, $p = .006$) and supervision experience ($\beta = 0.27$, $t = 2.77$, $p = .007$) were the two variables that predicted willingness to discuss sexual topics. Regression coefficients are presented in Table 8.

Table 8

Regression Coefficients

Variable		*B*	SE *B*	β	*t*	*p*
Step 1	(Constant)	3.46	0.33		10.48	.000
	Clinical experience**	0.91	0.29	0.32	3.18	.002
Step 2	(Constant)	3.15	0.34		9.34	.000
	Clinical experience**	0.78	0.28	0.28	2.81	.006
	Supervision experience**	0.39	0.14	0.27	2.77	.007

Note. Dependent variable: Willingness to discuss sexual topics. $R^2 = .32$ for Step 1. $R^2 = .18$ for Step 2; $^{**}p < .01$; $N = 90$.

H_{04} stated that there was no statistically significant predictive relationship between the independent variables (attitudes, knowledge, training, supervision experience, and clinical experience) and a therapist's willingness to discuss sexual topics with clients. Examination of the univariate statistics included in the model revealed that clinical experience ($\beta = 0.28$, $t = 2.81$, $p = .006$) and supervision experience ($\beta = 0.27$, $t = 2.77$, $p = .007$) were the two variables that predicted willingness to discuss sexual topics. Therefore, the null hypothesis was partially rejected.

Research Question 5, Hypothesis 5

What is the relationship between the independent variables of a therapist's age, sex, sexual orientation, number of years in practice, type of graduate program, relationship status, practice setting, or strength of religion and the dependent variable of the sexual comfort of a therapist? Research Question 5, Hypothesis 5 was investigated with the Pearson's r. The independent variables were a therapist's age, sex, sexual orientation, number of years in practice, type of graduate program, relationship status, practice setting, and strength of religion. The dependent variable was a therapist's

comfort discussing sexual topics with clients. Table 9 provides the bivariate correlation results.

Table 9

Research Question 5 Correlation Results

Variable	Pearson's *r*	*p*
Age	.04	.701
Sex	-.03	.770
Sexual orientation	-.02	.834
Years in practice	.09	.385
Graduate specialization	.05	.676
Practice setting	-.12	.265
Strength of religion	.01	.894

Note. Dependent Variable = Comfort discussing sexual topics. *N* = 90, two-tailed; Sex: 1=Female, 0=Male, Sexual Orientation: 1=Heterosexual, 0=Other, Graduate specialization: 1=Marriage and family, 0=Other, Practice setting: 1=Private practice, 0=Other, strength of religion: 1=Strong, 0=Other.

There was no significant relationship between the age of the therapist and a therapist's comfort discussing sexual topics, $r(88) = .04$, $p = .701$, two-tailed. There was no significant relationship between the sex of a therapist and a therapist's comfort discussing sexual topics, $r(88) = -.03$, $p = .770$, two-tailed. There was no significant relationship between a therapist's sexual orientation and a therapist's comfort discussing sexual topics, $r(88) = -.02$, $p = .834$, two-tailed. There was no significant relationship between a therapist's years in practice and a therapist's comfort discussing sexual topics, $r(88) = .09$, $p = .385$, two-tailed. There was no significant relationship between a therapist's graduate specialization and a therapist's comfort discussing sexual topics, $r(88) = .05$, $p = .676$, two-tailed. There was no significant relationship between a

therapist's practice setting and a therapist's comfort discussing sexual topics, $r(88) = -.12$, $p = .265$, two-tailed. There was no significant relationship between a therapist's strength of religion and a therapist's comfort discussing sexual topics, $r(88) = .01$, $p = .894$, two-tailed.

Table 10 presents the *p* values for the Fisher's exact tests between the willingness to discuss questions, as measured by the Sexuality Discussions with Clients Scale, and the independent variables, which are gender, strength of religion, age, years of practice, practice setting, graduate program, and sexual orientation. A statistically significant association, and thus the rejection of statistical independence of distributions, is defined in this analysis as $p \leq 0.05$.

Table 10

Sexual Discussions With Clients Scale Fisher's Exact Test Results

SDCS*	Gender	Strength of religion	Age	Years of practice	Practice setting	Graduate program	Sexual orientation
1	.219	.099	.253	.301	.995	.244	.648
2	.867	.625	.774	.599	.261	.398	.188
3	.145	.5	.732	.629	.126	.654	.611
4	.791	.577	.606	.743	.159	.342	.722
5	.779	.78	.165	.665	.919	.16	.356
6	.153	.595	.9	.411	.628	.984	.413
7	.142	.525	.644	.09	.386	.969	.591
8	.05	.904	.968	.244	.288	.597	.245
9	.679	.654	.484	.764	.751	.083	.835

*Sexuality Discussions with Clients Scale

For Question 1 of the scale, willingness to discuss STDs/STIs, none of the independent variables demonstrated statistically significant *p* values. For gender, it was

0.219; for strength of religion, 0.099; for age, 0.253; for years of practice, 0.301; for practice setting, 0.995, for graduate program, 0.244; and for sexual orientation, 0.648. The results of these tests suggest that demographic characteristics do not influence the therapists' willingness to discuss sexually transmitted diseases or infections. Similarly, there was not a statistically significant dependency for Question 2, willingness to discuss sexual dysfunction, on the independent demographic variables. The *p* value for gender was 0.867; for strength of religion, 0.625; for age, 0.774; for years of practice, 0.599; for practice setting, 0.261, for graduate program, 0.398; and for sexual orientation, 0.188. The results of these tests imply that demographic traits do not associate with the therapists' willingness to discuss sexual dysfunction issues.

For Question 3, willingness to discuss client satisfaction with their sexual life, the *p* value with gender was 0.145; with strength of religion, 0.5; with age, 0.732; with years of practice, 0.629; with practice setting, 0.126, with a graduate program, 0.654; and with sexual orientation, 0.611. As such, a therapist's willingness to discuss a client's sexual satisfaction does not a have statistically significant dependency on demographic traits. Concerning Question 4, willingness to discuss clients' typical sexual interaction pattern, the *p* value with gender was 0.791; with strength of religion, 0.577; with age, 0.606; with years of practice, 0.743; with practice setting, 0.159, with a graduate program, 0.342; and with sexual orientation, 0.722. Thus, demographic characteristics do not possess an apparent association with a therapist's willingness to discuss the client's typical sexual interaction pattern.

For Question 5, willingness to discuss reproduction and contraception, the *p* value with gender was 0.779; with strength of religion, 0.78; with age, 0.165; with years of practice, 0.665; with practice setting, 0.919, with a graduate program, 0.16; and with sexual orientation, 0.356. Therefore, willingness to discuss reproduction or contraception do not exhibit a clear relationship with any of the demographic traits. Concerning Question 6, willingness to discuss sexual orientation, the *p* value with gender was 0.153; with strength of religion, 0.595; with age, 0.9; with years of practice, 0.411; with practice setting, 0.628, with a graduate program, 0.984; and with sexual orientation, 0.413. In effect, the willingness to discuss sexual orientation does not appear to be contingent on any demographic attribute.

For Question 7, willingness to discuss sexual relationship enhancement, the *p* value with gender was 0.142; with strength of religion, 0.525; with age, 0.644; with years of practice, 0.09; with practice setting, 0.386, with a graduate program, 0.969; and with sexual orientation, 0.591. Because of these statistically insignificant values, demographics may not influence the willingness to discuss sexual relationship enhancement.

Concerning Question 8, willingness to discuss sexual abuse, gender was statistically significant ($p = 0.05$), which indicates that the therapists' gender may associate how willing they are to discuss sexual abuse. For the other independent variables, however, no statistically significant relationship was found and thus may not associate with this dependent variable. The *p* value with strength of religion was 0.904; with age, 0.968; with years of practice, 0.244; with practice setting, 0.288, with a

graduate program, 0.597; and with sexual orientation, 0.245. For Question 9, willingness to discuss sexually related issues when the client states that it is a concern, the *p* value with gender was 0.679; with strength of religion, 0.654; with age, 0.484; with years of practice, 0.764; with practice setting, 0.751, with a graduate program, 0.083; and with sexual orientation, 0.835. Because these *p* values exceeded the threshold of 0.05, I accepted the null hypothesis that the distribution of the dependent variable and the demographic variables were independent of each other.

As a whole, willingness to discuss sexually related topics, as defined within the constructs of the Sexuality Discussion with Clients Scale, may not be dependent on the therapists' demographic characteristics except gender, which may influence how willing they are to discuss sexual abuse with their clients.

H_{05} stated that there is no statistically significant relationship between the independent variables of a therapist's age, sex, sexual orientation, number of years in practice, type of graduate program, relationship status, practice setting, or strength of religion and the dependent variable of the sexual comfort of a therapist. I observed no significant relationships in the Pearson's *r*. Therefore, the null hypothesis was accepted as to the Pearson's *r* results. However, there was one statistically significant relationship found by Fisher's exact test, gender: gender, $p = .05$, was statistically significant when it came to a willingness to discuss sexual abuse. Therefore, the null hypothesis was partially rejected.

Research Question 6, Hypothesis 6

What is the relationship between the independent variables of a therapist's age, sex, sexual orientation, number of years in practice, type of graduate program, relationship status, practice setting, or strength of religion and the dependent variable of a therapist's willingness to discuss sexual topics? I investigated Research Question 6, Hypothesis 6 with the Pearson's *r*. The independent variables were a therapist's age, sex, sexual orientation, number of years in practice, type of graduate program, relationship status, practice setting, and strength of religion. The dependent variable was a therapist's comfort discussing sexual topics with clients. Table 10 provides the bivariate correlation results.

Table 11

Research Question 6 Correlation Results

Variable	Pearson's *r*	*p*
Age	.06	.552
Sex	-.02	.874
Sexual orientation	-.004	.967
Years in practice	.12	.260
Graduate specialization	-.20	.063
Practice setting	.22	.036*
Strength of religion	.06	.588

Note. *$p < .05$; Dependent Variable = Willingness to discuss sexual topics. $N = 90$, two-tailed; Sex: 1=Female, 0=Male, Sexual orientation: 1=Heterosexual, 0=Other, graduate specialization: 1=Marriage and family, 0=Other, Practice setting: 1=Private practice, 0=Other, strength of religion: 1=Strong, 0=Other.

There was no significant relationship between the age of the therapist and the therapists' willingness to discuss sexual topics, $r(88) = .06$, $p = .552$, two-tailed. There

was no significant relationship between the sex of a therapist and a therapist's willingness to discuss sexual topics, $r(88) = -.02$, $p = .874$, two-tailed. There was no significant relationship between a therapist's sexual orientation and a therapist's willingness to discuss sexual topics, $r(88) = -.004$, $p = .967$, two-tailed. There was no significant relationship between a therapist's years in practice and a therapist's willingness to discuss sexual topics, $r(88) = .12$, $p = .260$, two-tailed. There was no significant relationship between a therapist's graduate specialization and a therapist's willingness to discuss sexual topics, $r(88) = -.20$, $p = .063$, two-tailed. There was a significant relationship between a therapist's practice setting and a therapist's willingness to discuss sexual topics, $r(88) = .22$, $p = .036$, two-tailed. The coding of the variable for practice setting means that therapists who are willing to discuss sexual topics are more likely to be in private practice than in other settings. The coefficient of determination was (r^2) = .0484, which means that the practice setting can explain 4.84% of the variance in a therapist's willingness to discuss sexual topics. There was no significant relationship between a therapist's strength of religion and a therapist's willingness to discuss sexual topics, $r(88) = .06$, $p = .588$, two-tailed.

Table 12 displays the p values for the Fisher's exact tests between the variable of comfort while discussing sexuality questions and the independent variables, which are gender, strength of religion, age, years of practice, practice setting, graduate program, and sexual orientation. A statistically significant association, and thus, the rejection of statistical independence of distributions, is defined in this analysis as $p < 0.05$.

For Question 1, comfortable to discuss with clients, none of the independent variables demonstrated statistically significant *p* values. For gender, it was 0.877; for strength of religion, 0.633; for age, 0.173; for years of practice, 0.36; for practice setting, 0.596, for graduate program, 0.26; and for sexual orientation, 0.704. The results of these tests suggest that demographic characteristics do not influence a therapist's comfortability to discuss sexually-related topics with clients. Similarly, there was not a statistically significant dependency for Question 2, comfortable to discuss with students and trainees, on the independent demographic variables. The *p* value for gender was 0.871; for strength of religion, 0.101; for age, 0.183; for years of practice, 0.564; for practice setting, 0.71, for graduate program, 0.309; and for sexual orientation, 0.522. The results of these tests imply that demographic traits do not associate with a therapist's comfort to discuss sexually-related topics with students and trainees.

For Question 3, comfortable to discuss with supervisors, the *p* value with gender was 0.587; with strength of religion, 0.454; with age, 0.064; with years of practice, 0.862; with practice setting, 0.083, with a graduate program, 0.535; and with sexual orientation, 0.399. As such, a therapist's comfortability to discuss with supervisors does not have a statistically significant dependency on demographic traits. Concerning Question 4, comfortable to discuss with colleagues, the *p* value with gender was 0.811; with strength of religion, 0.051; with age, 0.394; with years of practice, 0.864; with practice setting, 0.608, with a graduate program, 0.055; and with sexual orientation, 0.689. Thus, demographic characteristics do not possess an apparent association with a therapist's comfortability to discuss with colleagues.

For Question 5, respond openly and confidently when sexual values are challenged, the *p* value with gender was 0.532; with strength of religion, 0.452; with age, 0.717; with years of practice, 0.392; with practice setting, 0.912, with a graduate program, 0.093; and with sexual orientation, 0.265. Therefore, demographic traits do not appear to influence a therapist's behavior when their sexual values are challenged. Concerning Question 6, communicate effectively about sexuality, the *p* value with gender was 0.524; with strength of religion, 0.598; with age, 0.022; with years of practice, 0.02; with practice setting, 0.827, with a graduate program, 0.869; and with sexual orientation, 0.444. In effect, the age of the therapist and years of practice may influence effective communication regarding sexually-related topics; for the other independent variables, such an association does not exist in these results.

For Question 7, use of appropriate sexual vocabulary, the *p* value with gender was 0.443; with strength of religion, 0.48; with age, 0.27; with years of practice, 0.173; with practice setting, 0.96, with a graduate program, 0.665; and with sexual orientation, 0.417. Because of these statistically insignificant values, demographics may not influence a therapist's use of appropriate sexual vocabulary. Concerning Question 8, sensitive and respectful of feelings and anxieties toward sexual matters, the *p* value with gender was 0.438; with strength of religion, 0.842; with age, 0.084; with years of practice, 0.498; with practice setting, 0.911, with a graduate program, 0.663; and with sexual orientation, 0.247. Because of these statistically insignificant values, demographics may not affect a therapist's sensitivity and respectfulness toward their clients' sexual matters.

For Question 9, encourage clients to explore their sexual values, the *p* value with gender was 0.711; with strength of religion, 0.795; with age, 0.742; with years of practice, 0.243; with practice setting, 0.843, with a graduate program, 0.198; and with sexual orientation, 0.671. The statistically insignificant results indicate that encouraging clients to explore their sexual values is not associated with demographic traits.

For Question 10, unconcerned about influencing client's sexuality, the *p* value with gender was 0.662; with strength of religion, 0.797; with age, 0.966; with years of practice, 0.012; with practice setting, 0.549, with a graduate program, 0.28; and with sexual orientation, 0.786. The statistically significant value with the years of experience a therapist has in their practice suggests that they may influence how concerned a therapist is about influencing a client's sexuality. For the other independent variables, such an association does not appear to exist in these results.

For Question 11, confidence in sexuality knowledge, the *p* value with gender was 0.787; with strength of religion, 0.261; with age, 0.572; with years of practice, 0.554; with practice setting, 0.303, with a graduate program, 0.355; and with sexual orientation, 0.606. The statistically insignificant results indicate that confidence in sexuality knowledge is not contingent on demographic traits. Concerning Question 12, appearing poised, the *p* value with gender was 0.977; with strength of religion, 0.921; with age, 0.68; with years of practice, 0.163; with practice setting, 0.982, with a graduate program, 0.31; and with sexual orientation, 0.788. The statistically insignificant results indicate that appearing poised is not related to demographic traits.

For Question 13, lacking respect and feeling intolerant, the *p* value with gender was 0.126; with strength of religion, 0.462; with age, 0.6; with years of practice, 0.473; with practice setting, 0.922, with a graduate program, 0.57; and with sexual orientation, 0.783. The statistically insignificant results indicate that this variable does not associate with demographic characteristics. Concerning Question 14, feel comfortable working with clients' sexual issues and concerns, the *p* value with gender was 0.319; with strength of religion, 0.972; with age, 0.457; with years of practice, 0.155; with practice setting, 0.289, with a graduate program, 0.382; and with sexual orientation, 0.362. As such, the statistically insignificant results demonstrate that the null hypothesis of distribution independence cannot be rejected.

In summary, for the comfort, variable-based questions, a therapist communicating effectively about sexuality may be related to age and years of practice. Additionally, how unconcerned a therapist is about influencing a client's sexuality may be associated with years of experience in their occupation. For other questions, a statistically significant association was not found.

H_{06} stated that there is no statistically significant relationship between the independent variables of a therapist's age, sex, sexual orientation, number of years in practice, type of a graduate program, relationship status, practice setting, or strength of religion and the dependent variable of a therapist's willingness to discuss sexual topics. There was a significant relationship between a therapist's practice setting and a therapist's willingness to discuss sexual topics, $r(88) = .22$, $p = .036$, two-tailed. However, there were no other significant relationships as determined by the Pearson's *r*.

Fisher's exact test did find two statistically significant relationships, with age, p = .022 and years of practice, p = .02 showing significance compared with responding openly and confidently when sexual values are challenged. Also, years of practice, *p* = .012, was significant with being unconcerned about influencing a client's sexuality. Therefore, the null hypothesis was partially rejected. The hypotheses and outcomes are summarized in Table 13.

Table 13

Hypothesis Summary and Outcomes

Hypothesis	Statistical test	Significance	Outcome
H_{01}: There is no statistically significant relationship between the independent variables (attitudes, knowledge, training, supervision experience, and clinical experience) and a therapist's willingness to discuss sexual topics with clients.	Pearson's *r*	*p* values ranged from .002 to .819	Null partially rejected
H_{02}: There is no statistically significant relationship between the independent variables (attitudes, knowledge, training, supervision experience, and clinical experience) and a therapist's comfort discussing sexual topics with clients.	Pearson's *r*	*p* values ranged from .078 to .931	Null accepted
H_{03}: There is no statistically significant predictive relationship between the independent variables (attitudes, knowledge, training, supervision experience, and clinical experience) and a therapist's comfort level with sexuality.	Stepwise multiple linear regression	No model generated	Null accepted
H_{04}: There is no statistically significant predictive relationship between the independent variables (attitudes, knowledge, training, supervision experience, and clinical experience) and a therapist's willingness to discuss sexual topics with clients.	Stepwise multiple linear regression	$p < .001$ for model, but only two variables were included	Null partially rejected
H_{05}: There is no statistically significant relationship between the independent variables of a therapist's age, sex, sexual orientation, number of years in practice, type of graduate program, relationship status, practice setting, or strength of religion and the dependent variable of sexual comfort of a therapist.	Pearson's *r*	*p* values ranged from .385 to .894	Null accepted
	Fishers exact test	*p* values ranged from .05 to .995	Null partially rejected
H_{06}: There is no statistically significant relationship between the independent variables of a therapist's age, sex, sexual orientation, number of years in practice, type of graduate program, relationship status, practice setting, or strength of religion and the dependent variable of a therapist's willingness to discuss sexual topics.	Pearson's *r*	*p* values ranged from .036 to .967.	Null partially rejected
	Fishers exact test	*p* values ranged from .012 to .972	Null partially rejected

Conclusions

Six research questions and six related hypotheses were originated for investigation. Statistical analyses included the Pearson's *r*, stepwise multiple linear regression, and the Fisher's exact test. The Pearson's *r* calculation determined that there was a significant, positive relationship between graduate sexuality training and a therapist's willingness to discuss sexual topics. There was a significant, positive relationship between supervision experience and a therapist's willingness to discuss sexual topics. There was a significant, positive relationship between clinical experience and a therapist's willingness to discuss sexual topics.

When examined collectively by stepwise multiple linear regression from the following independent variables, attitudes, knowledge, training, supervision experience, and clinical experience, I determined that clinical experience and supervision experience were the two variables that predicted a therapist's willingness to discuss sexual topics with clients respectively and accounted for 18% of the variance in a therapist's willingness to discuss sexual topics with clients. The Pearson's *r* determined that there was a significant relationship between a therapist's practice setting and a therapist's willingness to discuss sexual topics. The coding of the variable for practice setting means that therapists who are willing to discuss sexual topics are more likely to be in private practice than in other settings. Fisher's exact test determined there was a significant relationship between gender and willingness to discuss sexual abuse, a significant relationship between age and years of practice, and responding openly and confidently when sexual values are challenged. Also, Fisher's exact test found that there was a

statistically significant relationship between years of practice and how unconcerned a therapist is about influencing a client's sexuality. Implications are discussed in Chapter 5.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this quantitative cross-sectional study was to measure the relationships between marriage and family therapists' attitudes, knowledge, supervision experience, clinical experience, and graduate training and the dependent variables of comfort while discussing sexual topics and willingness to discuss topics regarding sexuality with clients. A secondary objective of this study was to assess how age, religion, sexual orientation, gender, and practice setting affected therapists' willingness to discuss sexual topics with clients and therapists' comfort levels while engaging clients a in discussion about their sexual issues.

The first finding was a statistically significant relationship between graduate sexuality training and a therapist's willingness to discuss sexual topics with a client as determined by the Pearson's *r* correlation test. The stepwise linear regression analysis indicated a statistically significant relationship between supervision experience and a therapist's willingness to discuss sexual topics with a client. A unique finding not previously reported in the literature was a statistically significant relationship between clinical supervision and a therapist's willingness to discuss sexual topics with a client. The two variables of supervision experience and clinical experience combined to account for 18% of the variance in a therapist's willingness to discuss sexual topics with a client. There was a significant relationship between a therapist's practice setting and a therapist's willingness to discuss sexual topics with a client.

In addition, Fisher's exact test results indicated a statistically significant relationship ($p = 0.05$) between gender and a therapist's willingness to discuss sexual

topics with clients and regarding a therapist's comfort in discussing sexual topics. I found statistically significant results for age and years in practice. The results of this study helped to fill in the gap in the literature by continuing the work that Harris and Hays (2008) started and Cupit (2010) continued. Although Cupit's findings were limited to counselors, the findings are relevant to the marriage and family therapy community. The instruments used in this study were predominantly drawn from Harris and Hays's study with a few modifications.

Interpretation of the Findings

The available literature was sparse regarding examination of the independent variables that correlated to a willingness to discuss sexual topics with clients and the comfort of the therapist while engaging in a discussion with the client. This gap in the literature (see Cupit, 2010; Decker, 2010; Dermer & Bachenberg, 2015; Dunk, 2007; LoFrisco, 2013; Yelton & Delfin, 2013) prompted the current study. The first finding was a significant positive correlation between graduate sexuality training and a therapist's willingness to discuss sexual topics, $r(88) = .31$, $p = .003$, two-tailed, coefficient of determination (r^2) = .0961. The more graduate sexuality training a therapist had, the more likely the therapist would be willing to discuss a sexual topic with a client. The graduate sexuality training variable accounted for 9.61% of the variance in a therapist's willingness to discuss sexual topics with a client. This finding was consistent with what Harris and Hays (2008) found that the more graduate-level sexuality-specific training therapists received, the more willing they were to initiate a conversation with clients about their sexual health. This finding was also consistent with the finding by Donovan

(2011), which was that graduate training had a strong correlation with the willingness to initiate a conversation with a client, with $t(84) = 2.016$, $p = .047$, two-tailed. Donovan's study also included 90 participants who were social workers and therapists who had a master's in social work. Donovan concluded that "this indicates that those with human sexuality training are more likely to initiate sexuality-related discussions with their clients than those without training" (p. 43). Cupit (2010) also found that graduate specializations affected therapists' willingness to discuss sexual topics with clients. Cupit's finding that human sexuality training and education were statistically significant ($r = .26$, $p < .01$) as a predictor variable in a regression analysis supported the finding from the current study that the more graduate sexuality training therapists have, the more likely they will be to discuss sexuality with clients.

The next finding was a significant positive correlation between supervision experience and a therapist's willingness to discuss sexual topics, $r(88) = .32$, $p = .002$, two-tailed, with the coefficient determination (r^2) = .1024. Findings indicated that 10.24% of the overall variance in a therapist's willingness to discuss sexual topics with a client could be explained by the supervision experience that the therapist had received. Harris and Hays (2008) found that supervision experience was the second highest predictor of a therapist's willingness to discuss a sexual topic with a client, with indirect effects ($r = .17$) and direct effects ($r = .20$) being statistically significant. Decker (2010) found that the more supervision experience therapists received, the more likely they were to initiate a conversation with a client regarding their sexual health. Cupit (2010) also found a statistically significant relationship between supervision experience and a

therapist's willingness to discuss sexual issues with a client with the results being $r = .38$, $p < .01$. Cupit found that 14% of the variance could be explained by supervision experience, (r^2) = .14, which was similar to the present study's finding. Given the alignment between Harris and Hays, Cupit, and Decker, supervision experience is an important factor influencing a therapist's willingness to discuss sexual topics.

The last finding from the current study was that clinical experience showed a significant positive correlation with a therapist's willingness to discuss sexual topics, $r(88) = .32$, $p = .002$, two-tailed, with the coefficient determination (r^2) = .1024. Findings indicated that 10.24% of the overall variance in a therapist's willingness to discuss sexual topics with clients is explained by the supervision experience that the therapist had received. Harris and Hays (2008) did not find a significant relationship between clinical experience and a therapist's willingness to discuss sexual topics but noted that the relationship was close to being statistically significant with $p = .08$. This result was the same as what Hays (2002) had found earlier. Therefore, it is reasonable to conclude that clinical experience has a statistically significant relationship with a therapist's willingness to discuss sexual topics. Decker (2010) found that clinical experience was an important component of a therapist's willingness to discuss sexual topics and should be combined with supervision to prepare therapists to initiate discussions. Donovan (2011) echoed this finding by noting that the more hands-on experience therapists have while in school, the more likely they will be to initiate a discussion with a client about the client's sexual well-being. Cupit (2010) did not find a relationship between clinical experience and a willingness to discuss sexual topics with a client. Harris and Hays pointed out that the

reason clinical experience was impactful was that their study focused on practicing therapists, whereas other studies had focused on students who may not have had significant clinical experience. There was no other plausible reason I could find for this discrepancy between the study findings.

The present study did not indicate significant relationships between sexual attitudes, knowledge, training, supervision experience, or clinical experience and comfort. These findings contrasted with those from other major studies. The reason may have been the smaller sample size. However, the size of the current study sample (N = 90) was similar to that used by other researchers, LoFrisco (2013) had 57 participants, Decker (2010) had 103 participants, and Donovan (2011) had 90 participants. The one relationship that came close to having statistical significance was sexual attitudes (permissiveness) with p = .079. This was consistent with Cupit's (2010) finding of only one small correlation between attitude (communion) and comfort. Cupit had a larger sample than the present study. The current findings contradicted what other researchers had found, which indicated that knowledge, supervision, and attitudes have the greatest impact on comfort (see Donovan, 2011; Cupit, 2010; M. S. Green et al., 2009; Harris & Hays, 2008; Juergens et al., 2009). This discrepancy may be due to the smaller sample size. However, because of the limited amount of research done in this area, it is difficult to explain the discrepancy in findings.

The first statistically significant finding from the stepwise linear regression analysis was that clinical experience predicted willingness to discuss sexual topics with a client ($\beta = 0.28$, $t = 2.81$, $p = .006$). The second statistically significant finding was that

supervision experience predicted willingness to discuss sexual topics with a client (β = 0.27, $t = 2.77$, $p = .007$). The regression model indicated $F(2, 87) = 9.28$, $p < .001$; $R^2 = .18$, compares with what Cupit (2010) found using the same variables, F=18.20, p < .01, R^2 =.163. Cupit found that supervision experience was a predictor variable of statistical significance with β = 0.380 and $R^2 = .144$. This was consistent with what I found. However, Cupit found that sexual attitude regarding birth control was the secondary predictor with β = -.137 and $R^2 = .163$. The present study indicated that clinical experience was the secondary predictor variable.

The first statistically significant finding from the Fisher's exact test was that gender significantly relates to a willingness to discuss sexual abuse, $p = .05$. This was a weak correlation, but it was consistent with findings from other studies, namely Decker (2010) and Easton (2015). The second and third statistically significant findings from the Fisher's exact test were that age, $p = .022$, and years of practice, $p = .02$, relate to comfort and responding openly and confidently when the client challenges sexual values. This was consistent with what Decker and Træen and Schaller (2013) found: Older, more experienced therapists were more comfortable and more willing to discuss sexual health issues with clients.

The implications of this study derived from Bowenian theory were that supervision experience (i.e., thoughtful instruction from trained professionals who have the experience and the capacity to provide guidance and insight to supervisees coupled with clinical experience) reduces the anxiety of initiating and discussing sexual topics. The concept of knowledge needed to be divided into two components. First, there is the

knowledge derived from courses, books, and lectures, and second, there is the knowledge derived from personal experience. Knowledge gained by the supervision and clinical experience appears to lower anxiety because of the strong correlation between supervision experience, clinical experience, and a willingness to discuss sexual topics with clients. Graduate sexuality training combines coursework and field experience. According to the Bowenian framework, one of the keys to reducing anxiety and increasing the likelihood of establishing a healthy therapeutic alliance is receiving hands-on experience in the field. Supervision is followed by clinical experience in which newly acquired tools can be used; this process builds confidence in the therapist's abilities, thereby reducing anxiety and increasing the willingness to discuss sexual topics with clients. The significant findings for supervision, clinical experience, and graduate sexuality training were consistent with the findings from Harris and Hays's (2008) study and provide data for further research.

Limitations of the Study

In this study, there were several limitations. First, the findings may not be generalizable to the overall therapist population because of the sample size. Also, the skewed response rate, with a largely female participant base, also limited the usability of the findings (see Field, 2013; Frankfort-Nachmias & Nachmias, 2008). The second limitation was the instrument size. With over 80 questions, this survey had the potential to be both intimidating and overwhelming to participants, which may have prompted a high opt-out rate. I indicated in the instructions that the average time to complete the survey was 15 minutes, but without incentives to offer, that may have been too much time

to commit. I also included the standard language that participants were free to leave at any time. Another limitation of this study was its lack of funding: There is not much funding for sexuality-focused research.

The quantitative correlational survey design also constituted a limitation. The findings are limited to correlations and cannot be used to establish causation. Additionally, findings could not provide the rich depth and background information that a qualitative or mixed-methods study might have provided. This study may have been limited by the influence of social desirability bias (see Larson & Bradshaw, 2017). Social desirability bias may have influenced participants to choose answers they believed others would find acceptable or would be in alignment with the community within which the therapist resides. Also, social desirability bias may have influenced this study by depriving the participants of the ability to explain their choices through a qualitative component (see Larson & Bradshaw, 2017).

Recommendations

In line with these limitations, I recommend that future research be focused on four specific areas. First, I recommend there be additional research on how attitudes impact a therapist's willingness to initiate and discuss sexual topics. While the present study did not find any such link, Cupit (2010) did, and other studies have as well. Therefore, I believe that more research should be done on this variable moving forward.

The second recommendation is for additional research on how supervision impacts a therapist's willingness to initiate and to discuss sexual topics. The present study found there was a strong correlation as did LoFrisco's (2013) dissertation, which found

there to be a strong statistical significance for improving therapists through supervision. Therefore, I recommend more research in this area to understand better how this experience can help improve a therapist's abilities in this area, and through that process, better inform and improve the supervision that students are receiving.

The third recommendation is further exploration of how graduate sexuality training impacts therapists. As this study was limited to a few questions on point, a mixed methods study would be beneficial to understand how graduate-level sexuality training (i.e., fieldwork or clinical experience inside of a course), impacts a therapist's willingness to initiate and discuss sexual topics and his or her comfort levels while conversing with the client.

The fourth and final recommendation is the development of a new sexual knowledge instrument because the one used in the present study was over 45 years old. It seems past time to develop a new instrument that can be used by researchers going forward.

Implications

In the current study, I aimed to fill in the gap in the literature by contributing to the existing body of knowledge by adding to the current information about what factors impact therapists and their willingness to discuss sexual topics with clients and their comfort during this process. One key contribution of this study was that it highlighted the importance of supervision in the development of therapists. Harris and Hays (2008) similarly found that this is important. In the future, universities and colleges that offer master's and doctoral programs in marriage and family therapy should increase the focus

on supervision as a means of enhancing a therapist's willingness to discuss. As LoFrisco (2013) pointed out, it is not the comfort of the therapist that is of paramount importance. Rather, it is the willingness of the therapist and the comfort of the client that should be the focus.

The second key contribution of this study that dovetails with the supervision element was the clinical experience factor, and how it has a strong correlation with a willingness to discuss sexual topics. Again, this is in line with what Harris and Hays (2008) found; it is important for future therapists to acquire sufficient clinical experience in dealing with sexual issues before graduation given how important sexuality is and how challenging a topic it can be to discuss.

I will disseminate the key findings from this study through my WordPress website to the marriage and family therapist community. This will assist the general community in informing what variables are statistically significant and strongly correlate with a willingness to discuss sexual issues and may aid in the increase of skill sets of therapists through attendance at workshops or local graduate courses focused on this particular area of study. Through the sharing of these findings, I hope to increase the attention that this area receives inside of the marriage and family therapy community and highlight that this continues to be an ongoing issue. Our communities thrive when individuals are healthy, happy, and balanced; this can only be achieved by receiving quality therapy that is attuned to the client's needs. The results of this will serve to add information for educators as they shape the curriculum and clinicals to better prepare therapists to deal with discussing sexuality with their clients.

Conclusion

There is a dearth of literature on the topic of therapists and their willingness to discuss sexual topics with clients. At present, there are only two studies, this one and Harris and Hays's (2008) that have addressed this issue. Therapists as a whole are still uncomfortable discussing sexual topics with clients (Dermer & Bachenberg, 2015). The lack of comfort is prevalent among early practitioners (Timm, 2009). The present study found that age and years of practice had a statistically significant relationship with comfort. Given that there was a strong correlation between supervision experience and willingness to discuss sexual topics and a strong correlation between clinical experience and willingness to discuss, it seems appropriate to draw the conclusion that, with extensive hands-on experience combined with years of practice experience and age, a therapist can have a level of comfort while discussing sexual topics. When one takes a step back and looks at the findings of this study, the overall conclusion is that several factors make a therapist more willing to step outside of their comfort zone and engage the client in a discussion about a sexual topic. Comfort comes after years of practice; comfort comes with willingness. The factors that underpin this process are the combination of direct supervision, clinical experience, and graduate training focused on sexuality. These taken together are what makes up a therapist's knowledge and experience and has the strongest correlation to increasing a therapist's willingness to discuss sexuality with a client.

I believe moving forward that the marriage and family therapy community needs to be comfortable with discussing sexual topics with clients; even more than that, I want

every therapist to be willing, despite any lack of comfort, to initiate the conversation. Educational institutions must be more aware of this need and look to fill it through requirements of coursework that provide sexuality-specific clinicals focused on dealing with sexual issues and supervision by therapists who are experienced and knowledgeable in this area. This will help address the needs of the clients in our respective communities and bring about positive social change as a result through having individuals whose needs are being met by marriage and family therapists.

References

Alessi, E. J., Dillon, F. R., & Kim, H. M. S. (2015). Therapist correlates of attitudes toward sexual minority individuals, affirmative counseling self-efficacy, and beliefs about affirmative practice. *Psychotherapy Research*, *26*(4), 1–13. https://doi.org/10.1080/10503307.2015.1026422

Alessi, E. J., Dillon, F. R., & Kim, H. M. S. (2015). Therapist correlates of attitudes toward sexual minority individuals, affirmative counseling self-efficacy, and beliefs about affirmative practice. *Psychotherapy Research*, *26*(4), 1–13. https://doi.org/ 10.1080/10503307.2015.1026422

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (5th ed.).* Arlington, VA: American Psychiatric Publishing.

Anderson, M. J. (2002). *Counselor comfort with sexual issues* (Unpublished doctoral dissertation). University of New Orleans, New Orleans, LA.

Andrews, W. C. (2000). Approaches to taking a sexual history. *Journal of Women's Health & Gender-Based Medicine*, *9*(1), 21–24. https://doi.org/10.1089/152460900318821

Arikan, F., Meydanlioglu, A., Ozcan, K., & Ozer, Z. C. (2015). Attitudes and beliefs of nurses regarding discussion of sexual concerns of patients during hospitalization. *Sexuality and Disability*, *33*(3), 327–337. Retrieved from https://link.springer.com/journal/11195

Baer, B. E., & Murdock, N. L. (1995). Non-erotic dual relationships between therapists and clients: The effects of sex, theoretical orientation, and interpersonal

boundaries. *Ethics & Behavior*, *5*(2), 131–145. https://doi.org/10.1207/s15327019eb0502_2

Bal, M. D., & Sahiner, N. C. (2015). Turkish nursing students' attitudes and beliefs regarding sexual health. *Sexuality and Disability*, *33*(2), 223–231. https://doi.org/10.1007/s1119

Bancroft, J. (2009a). *Human sexuality and its problems*. London, England: Churchill Livingstone/Elsevier.

Bancroft, J. (2009b). Sex therapy needs building not deconstruction. *Archives of Sexual Behavior, 38*, 1028–1030. Retrieved from https://kinseyinstitute.org/pdf/Bancroft%20ASB%202009.pdf

Banwari, G., Mistry, K., Soni, A., Parikh, N., & Gandhi, H. (2015). Medical students and interns' knowledge about and attitude toward homosexuality. *Journal of Postgraduate Medicine*, *61*(2), 95. https://doi.org/10.4103/0022-3859.153103

Bowen, M. (1976). Theory in the practice of psychotherapy. *Family Therapy: Theory and Practice*, *4*(1), 2–90. Retrieved from http://www.cflarchives.org/images/TheoryInThePractice.pdf

Burch, A. (2005). *Health care providers' knowledge, attitudes, and self-efficacy for working with spinal cord injured patients with diverse sexual orientations* (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses database (Order No. 3175668).

Byrne, M., Doherty, S., McGee, H. M., & Murphy, A. W. (2010). General practitioner views about discussing sexual issues with patients with coronary heart disease: A

national survey in Ireland. *BMC Family Practice*, *11*(1), 40. https://doi.org/10.1186/1471-2296-11-40

Campbell, D. T., & Stanley, J. C. (1966). *Experimental and quasi-experimental designs for research*. Chicago, IL: Rand McNally.

Carlson, M. D., & Morrison, R. S. (2009). Study design, precision, and validity in observational studies. *Journal of Palliative Medicine*, *12*(1), 77–82. https://doi.org/10.1089/jpm.2008.9690

Chapman, R., Watkins, R., Zappia, T., Nicol, P., & Shields, L. (2012). Nursing and medical students' attitude, knowledge and beliefs regarding lesbian, gay, bisexual and transgender parents seeking health care for their children. *Journal of Clinical Nursing, 21*(7–8), 938–945. https://doi.org/10.1111/j.1365-2702.2011.03892.x

Cohen, L., Manion, L., & Morrison, K. (2007). *Research methods in education* (6th ed.). London, England: RoutledgeFalmer.

Conrad, C., & Serlin, R. C. (2005). *The Sage handbook for research in education: Engaging ideas and enriching inquiry.* Thousand Oaks, CA: Sage.

Cort, E. M., Attenborough, J., & Watson, J. P. (2001). An initial exploration of community mental health nurses' attitudes to and experience of sexuality-related issues in their work with people experiencing mental health problems. *Journal of Psychiatric and Mental Health Nursing*, *8*(6), 489–499. https://doi.org/10.1046/j.1351-0126.2001.00425.x

Creswell, J. W. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches* (Laureate Education, Custom Ed.). Thousand Oaks, CA: Sage.

Creswell, J. W. (2013). *Research design: Qualitative, quantitative, and mixed methods approaches* (*4th ed.)* Los Angeles, CA: Sage.

Cupit, R. W. (2010. *Counselors' comfort levels and willingness to discuss sexual issues with couples they counsel* (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses database (Order No. 3414807).

Cushing, A., Evans, D., & Hall, A. (2005). Medical students' attitudes and behaviour toward sexual health interviewing: Short- and long-term evaluation of designated workshops. *Medical Teacher*, *27*(5), 422–428. https://doi.org/10.1080/01421590500046502

Decker, D. M. (2010). *Clinical supervision of marriage and family therapists and addressing the sexual needs of clients: A preliminary investigation* (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses database (Order No. 3418816).

Dermer, S., & Bachenberg, M. (2015). The importance of training marital, couple, and family therapists in sexual health. *Australian and New Zealand Journal of Family Therapy*, *36*(4), 492–503. https://doi.org/10.1002/anzf.1122

Diamond, L. M., & Huebner, D. M. (2012). Is good sex good for you? Rethinking sexuality and health. *Social and Personality Psychology Compass*, *6*(1), 54–69. https://doi.org/10.1111/j.1751-9004.2011.00408.x

Dixon-Woods, M., Regan, J., Robertson, N., Young, B., Cordel, C., & Tobin, M. (2002). Teaching and learning about human sexuality in undergraduate medical education.

Medical Education, *36*(5), 432–440. https://doi.org/10.1046/j.1365-2923.2002.01198.x

Doll, G. M. (2013). Sexuality in nursing homes: Practice and policy. *Journal of Gerontological Nursing*, *39*(7), 30–37. https://doi.org/10.3928/00989134-20130418-01

Donovan, C. (2011). *Examining the relationship between human sexuality training and therapist comfort addressing sexuality with clients* (Unpublished master's thesis). Smith College, Northampton, MA.

Dunk, P. (2007). Everyday sexuality and social work: Locating sexuality in professional practice and education. *Social Work and Society, 5*(2), 135–142. Retrieved from http://www.socwork.net/sws/article/view/112/401

Dyer, K., & das Nair, R. (2013). Why don't healthcare professionals talk about sex? A systematic review of recent qualitative studies conducted in the United Kingdom. *The Journal of Sexual Medicine*, *10*(11), 2658–2670. https://doi.org 10.1111/j.1743-6109.2012.02856.x

Easton, A. B. (2015). *Certified rehabilitation counselors' willingness to address sexuality-related concerns with clients with autism spectrum disorder* (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses database (Order No. 3715686)

Edmondson, A. C., & McManus, S. E. (2007). Methodological fit in management field research. *Academy of Management Review*, *32*(4), 1246–1264. Retrieved from https://www.cebma.org/wp-content/uploads/Edmondson-and-McManus-2007-.pdf

Eliason, M., DeJoseph, J., Dibble, S., Deevey, S., & Chinn, P. (2011). Lesbian, gay, bisexual, transgender, and queer/questioning nurses' experiences in the workplace. *Journal of Professional Nursing*, *27*(4), 237–244. https://doi.org/10.1016/j.profnurs.2011.03.003

Farmer, L. B., Welfare, L. E., & Burge, P. L. (2013). Counselor competence with lesbian, gay, and bisexual clients: Differences among practice settings. *Journal of Multicultural Counseling & Development*, *41*(4), 194–209. https://doi.org/10.1002/j.2161-1912.2013.00036.x

Field, A. (2013). *Discovering statistics using IBM SPSS statistics and sex and drugs and rock 'n' roll*. Los Angeles, CA: Sage.

Flaget-Greener, M., Gonzalez, C. A., & Sprankle, E. (2015). Are sociodemographic characteristics, education and training, and attitudes toward older adults' sexuality predictive of willingness to assess sexual health in a sample of US psychologists? *Sexual and Relationship Therapy*, *30*(1), 10–24. https://doi.org/10.1080/14681994.2014.948297

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. https://doi.org/10.1037/0735-7028.34.1.80

Frankfort-Nachmias, C., & Nachmias, D. (2008). Research designs: Cross-sectional and quasi-experimental designs. In C. Frankfort-Nachmias, D. Nachmias, & J. DeWaard (Eds.), *Research methods in the social sciences (7th ed.)* pp. 184–216. New York, NY.: Worth.

Fronek, P., Kendall, M., Booth, S., Eugarde, E., & Geraghty, T. (2011). A longitudinal study of sexuality training for the interdisciplinary rehabilitation team. *Sexuality and Disability, 29*(2), 87–100. https://doi.org/10.1007/s11195-010-9177-1

Giami, A., & Pacey, S. (2006). Training health professionals in sexuality. *Sexual and Relationship Therapy*, *21*(3), 267–271. https://doi.org/10.1080/14681990600812662

Goldstein, A. (2014). *Transgender counseling attitudes among first year graduate students in counseling and clinical psychology* (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses database (Order No. 1555751).

Gough, H. G. (1974). A 24-item version of the Miller-Fisk sexual knowledge questionnaire. *The Journal of Psychology*, *87*(2), 183–192. https://doi.org/10.1080/00223980.1974.9915689

Graham, C. A. (2016). Reconceptualising women's sexual desire and arousal in DSM-5. *Psychology & Sexuality*, *7*(1), 1–14. https://doi.org/10.1080/19419899.2015.1024469

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. https://doi.org/10.1111/j.1746-1561.1984.tb08908.x

Green, M. S., Murphy, M. J., & Blumer, M. L. (2010). Marriage and family therapists' comfort working with lesbian and gay male clients: The influence of religious practices and support for lesbian and gay male human rights. *Journal of*

Homosexuality, *57*(10), 1258–1273. https://doi.org/10.1080/00918369.2010.517072

Green, S. B., & Salkind, N. J. (2014). *Using SPSS for Windows and Macintosh: Analyzing and understanding data*. Boston, MA: Pearson.

Haag, S. C. (2008). *Psychotherapist factors that impact self -efficacy for working with clients presenting issues related to sexuality and sexual activities* (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses database (Order No. 3347219).

Haboubi, N. H., & Lincoln, N. (2003). Views of health professionals on discussing sexual issues with patients. *Disability and Rehabilitation*, *25*(6), 291–296. https://doi.org/10.1080/0963828021000031188

Haesler, E., Bauer, M., & Fetherstonhaugh, D. (2016). Sexuality, sexual health and older people: A systematic review of research on the knowledge and attitudes of health professionals. *Nurse Education Today*, *40*, 57–71. https://doi.org/10.1016/j.nedt.2016.02.012

Hanzlik, M. P., & Gaubatz, M. (2012). Clinical PsyD trainees' comfort discussing sexual issues with clients. *American Journal of Sexuality Education*, *7*(3), 219–236. https://doi.org/10.1080/15546128.2012.707080

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. https://doi.org/10.1111/j.1752-0606.2008.00066.x

Hartl, T. L., Zeiss, R. A., Marino, C. M., Zeiss, A. M., Regev, L. G., & Leontis, C. (2007). Clients' sexually inappropriate behaviors directed toward clinicians: Conceptualization and management. *Professional Psychology: Research and Practice*, *38*(6), 674–681. https://doi.org/10.1037/0735-7028.38.6.674

Hays, K. W. (2002). *The influence of sexuality education and supervision, clinical experience, perceived sex knowledge, and comfort with sexual content on therapists addressing sexuality issues with clients* (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses database (Order No. 3069179).

Helland, Y., Garratt, A., Kjeken, I., Kvien, T. K., & Dagfinrud, H. (2013). Current practice and barriers to the management of sexual issues in rheumatology: Results of a survey of health professionals. *Scandinavian Journal of Rheumatology*, *42*(1), 20–26. https://doi.org/10.3109/03009742.2012.709274

Hendrick, C., Hendrick, S. S., & Reich, D. A. (2006). The brief sexual attitudes scale. *The Journal of Sex Research, 43*(1), 76–86. https://doi.org/10.1080/00224490609552301

Higgins, A., Sharek, D., Nolan, M., Sheerin, B., Flanagan, P., Slaicuinaite, S., . . . Walsh, H. (2012). Mixed methods evaluation of an interdisciplinary sexuality education programme for staff working with people who have an acquired physical disability. *Journal of Advanced Nursing*, *68*(11), 2559–2569. https://doi.org/10.1111/jan.12146

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.

Hinchliff, S., Gott, M., & Galena, E. (2005). 'I daresay I might find it embarrassing': General practitioners' perspectives on discussing sexual health issues with lesbian and gay patients. *Health and Social Care in the Community*, *13*(4), 345–353. https://doi.org/10.1111/j.1365-2524.2005.00566.x

Hitlin, S., & Piliavin, J. A. (2004). Values: Reviving a dormant concept. *Annual Review of Sociology, 30*, 359–393. https://doi.org/10.1146/annurev.soc.30.012703.110640

IsHak, W. W., & Tobia, G. (2013). DSM-5 changes in diagnostic criteria of sexual dysfunctions. *Reproductive System & Sexual Disorders*, *2,* 122. https://doi.org/10.4172/2161-038X.1000122

Johnson, L., & Federman, E. J. (2014). Training, experience, and attitudes of VA psychologists regarding LGBT issues: Relation to practice and competence. *Psychology of Sexual Orientation and Gender Diversity*, *1*(1), 10. https://doi.org/10.1037/sgd0000019

Juergens, M. H. (2006). *Willingness of graduate students in rehabilitation counseling to discuss sexuality with clients* (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses database (Order No. 3222803).

Juergens, M. H., Smedema, S. M., & Berven, N. L. (2009). Willingness of graduate students in rehabilitation counseling to discuss sexuality with clients.

Rehabilitation Counseling Bulletin, 53(1), 34–43. https://doi.org/10.1177/0034355209340587

Kazukauskas, K. A., & Lam, C. S. (2010). Disability and sexuality: Knowledge, attitudes, and level of comfort among certified rehabilitation counselors. *Rehabilitation Counseling Bulletin, 54*(1), 15. https://doi.org/10.1177/0034355209348239

Kelsey, K., Stiles, B. L., Spiller, L., & Diekhoff, G. M. (2013). Assessment of therapists' attitudes toward BDSM. *Psychology & Sexuality*, *4*(3), 255–267. https://doi.org/10.1080/19419899.2012.655255

Kerr, M. E., & Bowen, M. (1988). *Family evaluation: An approach based on Bowen theory*. New York, NY: W.W. Norton.

Khadivzadeh, T., Ardaghi, M., Mazloum, S. R., & Modaresi, E. (2016). The relationship between midwifery students' attitudes toward couples' sexual relationships and their clinical skills in providing sexual health of counseling services. *Journal of Midwifery and Reproductive Health*, *4*(1), 530–539. https://doi.org/10.22038/JMRH.2016.6127

Kline, L. I. (2014). *Health care provision to transgender individuals: Understanding clinician attitudes and knowledge acquisition* (Master's thesis). Retrieved from ProQuest Dissertations and Theses database (Order No. 1570475).

Kothari, C. R. (2004). *Research methodology methods & mechniques (2nd ed.).* New Delhi, India: New Age International Publisher.

Kotronoulas, G., Papadopoulou, C., & Patiraki, E. (2009). Nurses' knowledge, attitudes, and practices regarding provision of sexual health care in patients with cancer:

Critical review of the evidence. *Supportive Care in Cancer*, *17*(5), 479–501. https://doi.org/10.1007/s00520-008-0563-5

Kuehl, R. O. (2000). *Design of experiments: Statistical principles of research design and analysis*. Pacific Grove, CA: Duxbury/Thomson Learning.

Lapinski, J., Sexton, P., & Baker, L. (2014). Acceptance of lesbian, gay, bisexual, and transgender patients, attitudes about their treatment, and related medical knowledge among osteopathic medical students. *The Journal of the American Osteopathic Association*, *114*(10), 788–796. https://doi.org/10.7556/jaoa.2014.153

Larson, K., & Bradshaw, C. (2017). Cultural competence and social desirability among practitioners: A systematic review of the literature. *Children and Youth Services Review, 76*, 100–111. https://doi.org/10.1016/j.childyouth.2017.02.034

Laumann, E. O., West, S., Glasser, D., Carson, C., Rosen, R., & Kang, J. H. (2007). Prevalence and correlates of erectile dysfunction by race and ethnicity among men aged 40 or older in the United States: From the male attitudes regarding sexual health survey. *The Journal of Sexual Medicine*,*4*(1), 57–65. https://doi.org/10.1111/j.1743-6109.2006.00340.x

Levesque, P. J. (2013). Nurse practitioners' knowledge, attitudes, and self-efficacy for working with transgender patients. *Clinical Nursing Studies*, *1*(4), 93. https://doi.org/10.5430/cns.v1n4p93

LoFrisco, B. (2013). *Counselor discomfort with sexual issues and supervisory role* (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses database (Order No. 3602540).

Lyons, H. Z., Bieschke, K. J., Dendy, A. K., Worthington, R. L., & Georgemiller, R. (2010). Psychologists' competence to treat lesbian, gay and bisexual clients: State of the field and strategies for improvement. Focus on Ethics. *Professional Psychology: Research & Practice*, *41*(5), 424–434. https://doi.org/10.1037/a0021121

Maciel, M., & Laganà, L. (2014). Older women's sexual desire problems: Biopsychosocial factors impacting them and barriers to their clinical assessment. *BioMed Research International, 2014*(1), 1-9. https://doi.org/10.1155/2014/107217

Magnan, M. A., & Reynolds, K. (2006). Barriers to addressing patient sexuality concerns across five areas of specialization. *Clinical Nurse Specialist, 20*(6), 285–292. https://doi.org/10.1097/00002800-200611000-00009

Marczyk, G. R., DeMatteo, D., & Festinger, D. (2005). *Essentials of research design and methodology*. New York, NY: Wiley.

McCabe, M. P., Sharlip, I. D., Lewis, R., Atalla, E., Balon, R., Fisher, A. D., . . . Segraves, R. T. (2016). Incidence and prevalence of sexual dysfunction in women and men: A consensus statement from the fourth international consultation on sexual medicine. *The Journal of Sexual Medicine, 13*(2), 144–152. https://doi.org/10.1016/j.jsxm.2015.12.034

McCune, K. C., Imborek, K. L., Ho, T., Hardy-Fairbanks, A. J., & Stockdale, C. K. (2015). Mapping change in medical student attitudes regarding lesbian, gay and

bisexual healthcare. *Proceedings in Obstetrics and Gynecology, 5*(2), 1–9. https://doi.org/10.17077/2154-4751.1278

McGeorge, C. R., Stone Carlson, T., & Farrell, M. (2015). To refer or not to refer: Exploring family therapists' beliefs and practices related to the referral of lesbian, gay, and bisexual clients. *Journal of Marital and Family Therapy, 42*(3), 466–480. https://doi.org/10.1111/jmft.12148

Millar, M. M., & Dillman, D. A. (2011). Improving response to web and mixed-mode surveys. *Public Opinion Quarterly, 75*(2), 249–269. https://doi.org/10.1093/poq/nfr003

Miller, S. A., & Byers, E. S. (2012). Practicing psychologists' sexual intervention self-efficacy and willingness to treat sexual issues. *Archives of Sexual Behavior, 41*(4), 1041–1050. https://doi.org/10.1007/s10508-011-9877-3

Monette, D. R., Sullivan, T. J., & DeJong, C. R. (2007). *Applied social research: A tool for the human services* (7th ed.). Florence, KY: Brooks Cole.

Moreno, A., Gan, C., Zasler, N., & McKerral, M. (2015). Experiences, attitudes, and needs related to sexuality and service delivery in individuals with traumatic brain injury. *NeuroRehabilitation, 37*(1), 99–116. https://doi.org/10.3233/NRE-151243

Moser, C. (2009). So where do we go from here? *Archives of Sexual Behavior, 38*(6), 1035–1036. https://doi.org/10.1007/s10508-009-9469-7

Nasserzadeh, S. (2009). "Sex therapy": A marginalized specialization. *Archives of Sexual Behavior, 38*(6), 1037–1038. https://doi.org/10.1007/s10508-009-9537-z

Nicol, P., Chapman, R., Watkins, R., Young, J., & Shields, L. (2013). Tertiary paediatric hospital health professionals' attitudes to lesbian, gay, bisexual and transgender parents seeking health care for their children. *Journal of Clinical Nursing, 22*(23-24), 3396–3405. https://doi.org/10.1111/jocn.12372

Nova, E. A. (2012). *Couple and family therapy students' attitudes toward bisexual clients* (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses database (Order No. 1509469)

Papaharitou, S., Nakopoulou, E., Moraitou, M., Tsimtsiou, Z., Konstantinidou, E., & Hatzichristou, D. (2008). Exploring sexual attitudes of students in health professions. *The Journal of Sexual Medicine, 5*(6), 1308–1316. https://doi.org/10.1111/j.1743-6109.2008.00826.x

Parker, L. P. (2012). *High school counselors' attitudes toward the sexuality of students with intellectual disabilities* (Doctoral Dissertation). Retrieved from ProQuest Dissertations and Theses database (Order No. 3550076).

Pauls, R. N., Kleeman, S. D., Segal, J. L., Silva, W. A., Goldenhar, L. M., & Karram, M. M. (2005). Practice patterns of physician members of the American Urogynecologic Society regarding female sexual dysfunction: Results of a national survey. *International Urogynecology Journal and Pelvic Floor Dysfunction, 16*(6), 460–467. https://doi.org/10.1007/s00192-005-1286-5

Pebdani, R. N. (2013). Rehabilitation counselor knowledge, comfort, approach, and attitude toward sex and disability. *Rehabilitation Research, Policy, and Education, 27*(1), 32–42. https://doi.org/10.1891/2168-6653.27.1.32

Polit, D. F., & Beck, C. T. (2006). *Essentials of nursing research: Methods, appraisal, and utilization*. Philadelphia, PA: Lippincott Williams & Wilkins.

Procter, J. E. (2013). *Religious fundamentalism, empathy, and attitudes toward lesbians and gays within the therapeutic relationship* (Doctoral Dissertation). Retrieved from ProQuest Dissertations and Theses database (Order No. 3565211).

Pukall, C. F. (2009). Sex therapy is special because it deals with sex. *Archives of Sexual Behavior, 38*(6), 1039–1040. https://doi.org/10.1007/s10508-009-9468-8

Pyrczak, F., & Bruce, R. R. (2000). *Writing empirical research reports* (3rd ed.). Los Angeles, CA: Pyrczak Publishing.

Ridley, J. (2006). The subjectivity of the clinician in psychosexual therapy training. *Sexual and Relationship Therapy, 21*(3), 319–331. https://doi.org/10.1080/14681990600774003

Riggs, D. W., & Bartholomaeus, C. (2016). Australian mental health nurses and transgender clients: Attitudes and knowledge. *Journal of Research in Nursing, 21*(3), 212–222. https://doi.org/10.1177/1744987115624483

Rogers, C. R. (1951). *Client-centered therapy: Its current practice, implications, and theory*. Boston, MA: Houghton Mifflin Company.

Rosen, R. C., & Bachmann, G. A. (2008). Sexual well-being, happiness, and satisfaction, in women: The case for a new conceptual paradigm. *Journal of Sex & Marital Therapy, 34*(4), 291–297. https://doi.org/10.1080/00926230802096234

Russell, E. B. (2012). Sexual health attitudes, knowledge, and clinical behaviors implications for counseling. *The Family Journal, 20*(1), 94–101. https://doi.org/10.1177/1066480711430196

Russell, E. B., Gates, T. G., & Viggiani, P. A. (2016). Sexual health knowledge and training in a child and adolescent mental health setting. *Social Work in Mental Health, 14*(4), 379–395. https://doi.org/10.1080/15332985.2015.1008171

Rutter, P. A., Leech, N. N., Anderson, M., & Saunders, D. (2010). Couples counseling for a transgender-lesbian couple: Student counselors' comfort and discomfort with sexuality counseling topics. *Journal of GLBT Family Studies, 6*(1), 68–79. https://doi.org/10.1080/15504280903472816

Saunamäki, N., Andersson, M., & Engström, M. (2010). Discussing sexuality with patients: Nurses' attitudes and beliefs. *Journal of Advanced Nursing, 66*(6), 1308–1316. https://doi.org/10.1111/j.1365-2648.2010.05260.x

Schnarch, D. M. (1991). *Constructing the sexual crucible: An integration of sexual and marital therapy*. New York, NY: W. W. Norton.

Schnarch, D. M. (1998). *Passionate marriage: Keeping love & intimacy alive in committed relationships*. New York, NY: Owl Books.

Shalev, O., & Yerushalmi, H. (2009). Status of sexuality in contemporary psychoanalytic psychotherapy as reported by therapists. *Psychoanalytic Psychology, 26*(4), 343–361. https://doi.org/10.1037/a0017719

Shepherd, L., Heke, S., & O'Donovan, A. (2009). Sexual problems in two inner-city London sexual health centres: Prevalence, attributions, and need for psychosexual

services. *Sexual and Relationship Therapy, 24*(3-4), 249–260. https://doi.org/10.1080/14681990903242278

Shifren, J. L., Monz, B. U., Russo, P. A., Segreti, A., & Johannes, C. B. (2008). Sexual problems and distress in United States women: Prevalence and correlates. *Obstetrics and Gynecology, 112*(5), 970–978. https://doi.org/10.1097/AOG.0b013e3181898cdb

Sidi, H., Loh, S. F., Mahadevan, R., Puteh, S. E. W., Musa, R., Wong, C. Y., . . . Zakaria, H. (2013). Knowledge and attitude on sex among medical students of a Malaysian university: A comparison study. *Asia-Pacific Psychiatry, 5*(Suppl 1), 103–109. https://doi.org/10.1111/appy.12053

Simpson, G., Anwar, S., Wilson, J., & Bertapelle, T. (2006). Improving the rehabilitative management of client sexual health concerns after neurological disability: Evaluation of a staff sexuality training programme in New Zealand. *Clinical Rehabilitation, 20*(10), 847–859. https://doi.org/10.1177/0269215506072180

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*(1), 26–32. https://doi.org/10.1080/01614576.1998.11074203

Stead, M. L., Brown, J. M., Fallowfield, L., & Selby, P. (2003). Lack of communication between healthcare professionals and women with ovarian cancer about sexual issues. *British Journal of Cancer, 88*(5), 666–671. https://doi.org/10.1038/sj.bjc.6600799

St. Lawrence, J. S., Montaño, D. E., Kasprzyk, D., Phillips, W. R., Armstrong, K., & Leichliter, J. S. (2002). STD screening, testing, case reporting, and clinical and partner notification practices: A national survey of US physicians. *American Journal of Public Health, 92*(11), 1784–1788. https://doi.org/10.2105/AJPH.92.11.1784

Strong, K. L., & Folse, V. N. (2015). Assessing undergraduate nursing students' knowledge, attitudes, and cultural competence in caring for lesbian, gay, bisexual, and transgender patients. *The Journal of Nursing Education, 54*(1), 45–49. https://doi.org/10.3928/01484834-20141224-07

Stuart, C. (2014). Exploring professional attitudes. *Child and Youth Care, 183*, 23–26. Retrieved from http://www.cyc-net.org/cyc-online/may2014.pdf

Sung, S. C., Huang, H. C., & Lin, M. H. (2015). Relationship between the knowledge, attitude, and self-efficacy on sexual health care for nursing students. *Journal of Professional Nursing, 31*(3), 254–261. https://doi.org/10.1016/j.profnurs.2014.11.001

Sung, S. C., & Lin, Y. C. (2013). Effectiveness of the sexual healthcare education in nursing students' knowledge, attitude, and self-efficacy on sexual healthcare. *Nurse Education Today,33*(5), 498–503. https://doi.org/10.1016/j.nedt.2012.06.019

Szklo, M., & Nieto, F. J. (2014). *Epidemiology: Beyond the basics* (3rd ed.). Sudbury, MA: Jones and Bartlett.

Thomason, A., Capps, N., Lefler, L., & Richard-Davis, G. (2015). Factors affecting gynecologic and sexual assessment in older women: A lesson for primary care providers. *Healthcare, 3*(3), 683–694. https://doi.org/10.3390/healthcare3030683

Timm, T. M. (2009). "Do I really have to talk about sex?" Encouraging beginning therapists to integrate sexuality into couple's therapy. *Journal of Couple & Relationship Therapy, 8*(1), 15–33. https://doi.org/10.1080/15332690802626692

Træen, B., & Schaller, S. (2013). Talking to patients about sexual issues: Experiences of Norwegian psychologists. *Sexual and Relationship Therapy, 28*(3), 281–291. https://doi.org/10.1080/14681994.2013.768338

Tugut, N., & Golbasi, Z. (2015). Sexuality assessment knowledge, attitude, and skill of nursing students: An experimental study with control group. *International Journal of Nursing Knowledge, 28*(3), 123–130. https://doi.org/10.1111/2047-3095.12127

U.S. Department of Labor, Bureau of Labor Statistics. (2017, March 31). Occupational Employment and Wages, May 2016. Retrieved from https://www.bls.gov/OES/current/oes211013.htm

Valvano, A. K., West, L. M., Wilson, C. K., Macapagal, K. R., Penwell-Waines, L., Waller, J. L., & Stepleman, L. M. (2014). Health professions students' perceptions of sexuality in patients with physical disability. *Sexuality and Disability, 32*(3), 413–427. https://doi.org/10.1007/s11195-014-9347-7

Verschuren, J. E., Enzlin, P., Geertzen, J. H., Dijkstra, P. U., & Dekker, R. (2013). Sexuality in people with a lower limb amputation: A topic too hot to

handle? *Disability and Rehabilitation, 35*(20), 1698–1704. https://doi.org/10.3109/09638288.2012.751134

Vieira, T. C. S. B., de Souza, E., da Silva, I., Torloni, M. R., Ribeiro, M. C., & Nakamura, M. U. (2015). Dealing with female sexuality: Training, attitude, and practice of obstetrics and gynecology residents from a developing country. *Journal of Sexual Medicine, 12*(5), 1154–1157. https://doi.org/10.1111/jsm.12875

Voss, J. A. C. (2015). *Alternative sexual lifestyles: An exploration of client needs, therapist competencies, and training* (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses database (Order No. 3728624).

Ward, P., Clark, T., Zabriskie, R., & Morris, T. (2012). Paper/pencil versus online data collection: An exploratory study. *Journal of Leisure Research, 44*(4), 507–530. https://doi.org/10.1080/00222216.2012.11950276

Weerakoon, P., Sitharthan, G., & Skowronski, D. (2008). Online sexuality education and health professional students' comfort in dealing with sexual issues. *Sexual and Relationship Therapy, 23*(3), 247–257. https://doi.org/10.1080/14681990802199926

Weerakoon, P., & Stiernborg, M. (1996). Sexuality education for healthcare professionals: A critical review of the literature. *Annual Review of Sex Research, 7*(1), 181–218. https://doi.org/10.1080/10532528.1996.10559913

West, L. M., Stepleman, L. M., Wilson, C. K., Campbell, J., Villarosa, M., Bodie, B., & Decker, M. (2012). It's supposed to be personal: Personal and educational factors

associated with sexual health attitudes, knowledge, comfort and skill in health profession students. *American Journal of Sexuality Education, 7*(4), 329–354. https://doi.org/10.1080/15546128.2012.740945

Wilson, C. K., West, L., Stepleman, L., Villarosa, M., Ange, B., Decker, M., & Waller, J. L. (2014). Attitudes toward LGBT patients among students in the health professions: Influence of demographics and discipline. *LGBT Health, 1*(3), 204–211. https://doi.org/10.1089/lgbt.2013.0016

Wolf, C. (2012). Exploring the sexual attitudes of physician assistant students: Implications for obtaining a sexual history. *The Journal of Physician Assistant Education, 23*(4), 30–34. https://doi.org/10.1097/01367895-201223040-00007

World Health Organization. (2006). *Defining sexual health: Report of a technical consultation on sexual health.* Retrieved from http://www.who.int/reproductivehealth/topics/gender_rights/defining_sexual_health.pdf

Yelton, M. M., & Delfin, N. M. (2015). *An overview of sexuality in clinical practice* (Unpublished master's thesis). California State University, Sacramento, CA.

Zimmerman, V. (2015). Clinical psychology students' perceived training in working with transgender clients: An exploratory study. doctoral papers and masters projects. (Unpublished doctoral dissertation). University of Denver, Denver, CO.

Appendix A: Search Terms

The following are keywords and phrases I used both singularly and combined in my search. In every search, I used the terms *therapist, counselor, psychologist, doctor,* and *nurse* (and would change the terms and re-run the search to determine if there was any further research): *Therapist willingness to discuss sexuality, therapist willingness to initiate discussions sexual/sexuality, therapist discuss sexuality, therapist attitudes on sexuality, therapist comfort with sexual topics/sexuality, therapist sexual knowledge, therapist sexual comfort, therapist supervision sexual/sexuality, therapist experience sexual/sexuality, therapist sexual attitudes, therapist graduate sexuality attitude, and therapist attitude sexual/sexuality*.

Appendix B: Instrument Permissions

Gmail by Google

Byron Moore <byron.moore@waldenu.edu>

RE: Dissertation Instrumentation and Journal Publication Request/Gratis/Figure/Dissertation/Oct. 21

1 message

US Journal Permissions <USJournalPermissions@taylorandfrancis.com> Fri, Oct 21, 2016 at 8:30 AM
To: Byron Moore <byron.moore@waldenu.edu>

Dear Mr. Moore,

I am sending our gratis permission for the use of our article figure in your forthcoming dissertation.

Thank you.

Mary Ann Muller – Permissions Coordinator, US Journals Division

My New Work Schedule Beginning January 25th Week is Tuesday, Wednesday, and Friday.

Find digital versions of our articles on: www.tandfonline.com to use RightsLink, our online permissions web page, for immediate processing of your permission request.

Please Note: Permissions requests for US journals may take up to three weeks for processing due to demand.

Taylor & Francis Group
an **informa** business

530 Walnut Street – 8th floor
Philadelphia | PA | 19106 | United States of America
Direct line: ☎ 215-606-4334
Main Office: ☎ 215 625 8900, ext. 14334

maryann.muller@taylorandfrancis.com
www.taylorandfrancisgroup.com
www.tandfonline.com

This electronic message and all contents transmitted with it are confidential and may be privileged. They are intended solely for the addressee. If you are not the intended recipient, you are hereby notified that any disclosure, distribution, copying or use of this message or taking any action in reliance on the contents of it is strictly prohibited. If you have received this electronic message in error, please destroy it immediately, and notify the sender.

Informa Group plc | Registered in England & Wales No. 3099067 5 Howick Place, London, SW1P 1WG

From: Byron Moore [mailto:byron.moore@waldenu.edu]
Sent: Monday, October 10, 2016 8:21 PM
To: US Journal Permissions
Subject: Dissertation Instrumentation and Journal Publication Request/Gratis/Figure/Dissertation/Oct. 21

Dear Taylor and Francis,

I am a doctoral candidate at Walden University in their Human Services program with a specialization in Family Studies and Intervention Strategies. I am currently working on my dissertation which is on Therapist's comfort and willingness to discuss sexual issues with clients. I am interested in using the 24-item Miller-Fisk Sexual Knowledge Questionnaire in my forthcoming dissertation. Specifically the article by Gough, H.G. "Figure/Table: A 24-item version of the Miller-Fisk Sexual Knowledge Questionnaire." *The Journal of Psychology*, 87 (1974): 183-192. If you have any questions, please contact me at ☎ 602-908-6744 or reply to this email. Thank you for your time!

Sincerely yours,

Byron J. Moore

P102116-03.pdf
35K

Taylor & Francis
Taylor & Francis Group

Permissions

T & F Reference Number: P102116-03

10/21/2016

Byron J. Moore
Walden University
byron.moore@waldenu.edu

Dear Mr. Moore:

We are in receipt of your request to use the 24-item Miller-Fisk Sexual Knowledge Questionnaire from the following article

> Gough, H.G. (1974)
> A 24-item version of the Miller-Fisk Sexual Knowledge Questionnaire
> *The Journal of Psychology*, 87 (2): 183-192.
> DOI: 10.1080/00223980.1974.9915689

For your use in your dissertation

Permission is granted to reproduce in print and electronic.

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

This permission is for non-exclusive English world rights.

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

Full acknowledgment must be included showing article title, author, and full Journal title, reprinted by permission of Taylor & Francis, LLC (http://www.tandfonline.com).

Thank you very much for your interest in Taylor & Francis publications. Should you have any questions or require further assistance, please feel free to contact me directly.

Sincerely,

Mary Ann Muller

Permissions Coordinator

E-mail: maryann.muller@taylorandfrancis.com

Telephone: 215.606.4334

Gmail by Google

Byron Moore <byron.moore@waldenu.edu>

Dissertation Instrument Request

2 messages

Byron Moore <byron.moore@waldenu.edu> Tue, Oct 11, 2016 at 3:59 PM
To: Rachel.cupit@harpethhall.org

Dear Dr. Cupit,

I am a doctoral candidate at Walden University in their Human Services program with a specialization in Family Studies and Intervention Strategies. I am currently working on my dissertation which is on Marriage and Family Therapist's comfort and willingness to discuss sexual issues with clients. I am interested in using your demographic information survey which you developed in 2009 in my dissertation research. How can I receive permission to use your scale? Also any guidance you can provide regarding Dr. Harris' instruments would be most helpful, he has provided me permission but his interests have taken him in a different direction and as you actually used them I'm slightly confused as to which items correlate to each scale. Again any assistance is greatly appreciated, thank you for your time, your help on this and your contribution to this area of the literature! If you have any questions please feel free to contact me at ☎ 602-908-6744 or reply to this email.

Sincerely yours,

Byron J. Moore

Rachel Cupit <rachel.cupit@harpethhall.org> Wed, Oct 12, 2016 at 5:41 AM
To: Byron Moore <byron.moore@waldenu.edu>

Byron,

Yes, you have my permission to use the Demographic scale that I created. You may also want to contact Ashley Grinonneau-Denton, ashley@clevelandrelationshiptherapy.com, who recently asked if she could replicate my study. She may be a good resource. Honestly, it has been so long that I don't really have a strong recollection. I would recommend reading the instrumentation section of my dissertation and see if that is helpful. If you have specific questions, I am happy to try to clarify anything for you.

Good luck on your dissertation!

Take care,
Rachel
[Quoted text hidden]
--
Rachel Wieck Cupit, PhD
Upper School Counselor
Harpeth Hall School
☎ *(615)346-0086*
rachel.cupit@harpethhall.org

"Harpeth Hall educates young women to think critically, to lead confidently and to live honorably."

Gmail by Google

Byron Moore <byron.moore@waldenu.edu>

Dissertation Instrumentation Request

4 messages

Byron Moore <byron.moore@waldenu.edu> Mon, Oct 10, 2016 at 4:05 PM
To: s.hendrick@ttu.edu, c.hendrick@ttu.edu

Dear Dr. Hendrick,

I am a doctoral candidate at Walden University in their Human Services program with a specialization in Family Studies and Intervention Strategies. I am currently working on my dissertation which is on Therapist's comfort and willingness to discuss sexual issues with clients. I am interested in using your Brief Sexual Attitudes Scale in my dissertation research. How can I receive permission to use your scale? Any assistance is greatly appreciated, thank you for your time, your help on this and your contribution to this area of the literature! If you have any questions please feel free to contact me at ☎ 602-908-6744 or reply to this email.

Sincerely yours,

Byron J. Moore

Hendrick, S <s.hendrick@ttu.edu> Tue, Oct 11, 2016 at 7:53 AM
To: Byron Moore <byron.moore@waldenu.edu>

Byron,

You have our full permission to use the Brief Sexual Attitudes Scale (BSAS) in your dissertation research. For your convenience, I have attached a copy of the scale and an article describing its development. Best wishes in your dissertation work.

Susan Hendrick

Susan S. Hendrick, Ph.D.

Paul Whitfield Horn Professor of Psychological Sciences, Emeritus

Texas Tech University

From: Byron Moore [mailto:byron.moore@waldenu.edu]
Sent: Monday, October 10, 2016 7:06 PM
To: Hendrick, S; c.hendrick@ttu.edu
Subject: Dissertation Instrumentation Request

[Quoted text hidden]

2 attachments

BSAS.doc
42K

2006BSASArticle.pdf
854K

Byron Moore <byron.moore@waldenu.edu> Tue, Oct 11, 2016 at 3:44 PM
To: "Hendrick, S" <s.hendrick@ttu.edu>

Dear Dr. Hendrick,

Thank you so much, I really appreciate it!

Sincerely yours,

Byron
[Quoted text hidden]

Hendrick, S <s.hendrick@ttu.edu> Tue, Oct 11, 2016 at 5:04 PM
To: Byron Moore <byron.moore@waldenu.edu>

☺

From: Byron Moore [mailto:byron.moore@waldenu.edu]
Sent: Tuesday, October 11, 2016 6:44 PM
To: Hendrick, S
Subject: Re: Dissertation Instrumentation Request

Dear Dr. Hendrick,

Thank you so much, I really appreciate it!

Sincerely yours,

Byron

On Tue, Oct 11, 2016 at 7:53 AM, Hendrick, S <s.hendrick@ttu.edu> wrote:

Byron,

You have our full permission to use the Brief Sexual Attitudes Scale (BSAS) in your dissertation research. For your convenience, I have attached a copy of the scale and an article describing its development. Best wishes in your dissertation work.

Susan Hendrick

Susan S. Hendrick, Ph.D.

Paul Whitfield Horn Professor of Psychological Sciences, Emeritus

Texas Tech University

From: Byron Moore [mailto:byron.moore@waldenu.edu]
Sent: Monday, October 10, 2016 7:06 PM
To: Hendrick, S; c.hendrick@ttu.edu
Subject: Dissertation Instrumentation Request

Dear Dr. Hendrick,

I am a doctoral candidate at Walden University in their Human Services program with a specialization in Family Studies and Intervention Strategies. I am currently working on my dissertation which is on Therapist's comfort and willingness to discuss sexual issues with clients. I am interested in using your Brief Sexual Attitudes Scale in my dissertation research. How can I receive permission to use your scale? Any assistance is greatly appreciated, thank you for your time, your help on this and your contribution to this area of the literature! If you have any questions please feel free to contact me at ☎ 602-908-6744 or reply to this email.

Sincerely yours,

Byron J. Moore

Gmail by Google

Byron Moore <byron.moore@waldenu.edu>

Dissertation Instrumentation Request from Byron Moore

3 messages

Byron Moore <byron.moore@waldenu.edu> Mon, Oct 10, 2016 at 3:58 PM
To: smharris@umn.edu

Dear Dr. Harris,

I am a doctoral student in Human Services with a Specialization in Family Studies and Intervention Strategies at Walden University. I am in the beginning stages of my dissertation research. For my dissertation, I am interested in researching therapist comfort levels and willingness to discuss topics involving sexuality with clients. I have read many articles on the influencing variables, including the work that you and Dr. Hays did together. I believe this area to be terribly under-addressed and so my research topic has led me to wish to research this area and further the work you did in your article "Family Therapist Comfort with and Willingness to Discuss Client Sexuality". I would like to explore the impact that attitudes has upon dependent variables of comfort and willingness to discuss and with your permission I would like to utilize the scales you developed and used in "Family Therapist Comfort with and Willingness to Discuss Client Sexuality". If you could provide me with those scales you used in that article along with a way to score them and which items belong to which scale that would be very helpful. I am very thankful for your research as it the cornerstone of this area moving forward and if I can contribute to further this area that would be fantastic. Thank you for your time in this matter, I appreciate any suggestions or feedback for my dissertation and thank you for your time. Please contact me at your earliest opportunity at ☎ 602-908-6744 or at byron.moore@waldenu.edu.

Sincerely yours,

Byron

Steven Harris <smharris@umn.edu> Tue, Oct 11, 2016 at 8:32 AM
To: Byron Moore <byron.moore@waldenu.edu>

Byron,

I'm happy to help where I can. That particular study is not reflective of my current area of research but several people have contacted me and requested permission to use our instrument. I will forward those emails to you and you can follow up with those folks. I'll also send the instrument to you and you have my permission to use the instrument(s) as long as you cite it properly. Best of luck to you in your research.

Dr. Harris

[Quoted text hidden]

--

Steven M. Harris, Ph.D., LMFT
Professor and Program Director
Couple and Family Therapy

Associate Project Director
Minnesota Couples on the Brink Project
www.mncouplesonthebrink.org

University of Minnesota
290 McNeal Hall
St. Paul, MN 55108
☎ (612) 625-3735

Byron Moore <byron.moore@waldenu.edu> Tue, Oct 11, 2016 at 3:43 PM
To: Steven Harris <smharris@umn.edu>

Dear Dr. Harris,

Thank you so much, I really appreciate it!

Sincerely yours,

Byron
[Quoted text hidden]