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Examining the relationship between human sexuality training and therapist comfort with addressing sexuality with clients

Cari Lee Merritt
Smith College

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Cari Donovan
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ABSTRACT

The purpose of this study was to examine the relationship between human sexuality training and clinical social workers' comfort with addressing sexuality issues with clients. A mixed methods survey was responded to by 90 participants who had graduated from Smith SSW between the years 2000 and 2009. Participants were asked questions pertaining to their level of comfort with discussions about sexuality; their attitudes about sexuality; and their knowledge and comfort with issues regarding erotic transference.

The results of this study indicate that participants who received human sexuality training had a greater degree of comfort with discussing sexuality issues with their clients than those who had not received training. Respondents who had received some sort of human sexuality training reported that they initiate sexuality related discussions with clients and viewed such discussions as necessary more often than those with no training. A positive correlation was found between the amount of human sexuality training respondents had received and their inclusion of sexuality related questions in biopsychosocial assessments. Additionally, a positive correlation was found between the amount of human sexuality training received and respondents' reports of detection ability and frequency of experiences with erotic transference encounters in therapeutic relationships. This indicates that the more human sexuality training clinical social workers receive, the more comfortable they are to address their clients' sexuality related issues and the more prepared they are to detect erotic transference.

EXAMINING THE RELATIONSHIP BETWEEN HUMAN SEXUALITY TRAINING

AND THERAPIST COMFORT WITH ADDRESSING SEXUALITY WITH CLIENTS

A project based upon an independent investigation, submitted in partial fulfillment of the requirements for the degree of Master of Social Work.

Cari Donovan

Smith College School for Social Work
Northampton, Massachusetts 01063

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CHAPTER I

Introduction

Researchers conclude that by adulthood, individuals' self concepts include sexuality. Concepts that enhance or damage self-esteem play a role in the overall context in which sexual behaviors occur. These internal concepts can be linked to psychosocial development as they pertain to psychodynamic theories of attachment and individuation (Davis, Shaver, & Vernon, 2004; Giordano & Rush, 2010). Indeed, as McGuire & Barber (2010) note, "The evidence linking aspects of sexuality highlights the need to consider sexuality as a multifaceted feature of the self" (p. 303).

Theorists have found that sexual expression in the context of love and intimacy is a part of a larger system of human expressions. Sexual communication and other forms of communication are not necessarily mutually exclusive (Levine, 2010; Knafo, 2010). At times, sexual expression can become a central focal point for intimate partners in communicating needs, desires, affection, nurturance, trust, and vulnerabilities. If a couple, of any sexual orientation, spends many years together, they move through several major stages of adult sexual development and significant relationship problems can inhibit satisfying sexual interactions (Levine, 2010).

Researchers have noted that due to the lack of clinical training in the area of human sexuality, therapists and other allied health care professionals do not feel properly prepared to address issues of sexuality with their clients and are likely to avoid or dismiss these issues when they arise (Anderson, 1986; Haboubi & Lincoln, 2003; Pope, Sonne, & Holroyd, 1993; Reissing

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& Giulio, 2010). Without proper training in the area of human sexuality, clinicians tend to experience anxiety, guilt, confusion, and shame (Pope et al., 1993). These feelings can create barriers that prevent clinicians from having discussions with supervisors and colleagues, further impeding his or her ability to understand and respond to sexuality related issues that arise in a therapeutic setting. Latent and manifest behavioral and verbal content related to sexuality and erotic transference may go unrecognized, unacknowledged or misinterpreted by a clinician and can result in unethical behaviors and psychological damage to clients. Education and training in human sexuality may reduce the risk of misinterpreting and mishandling sexuality related discourse and help clinicians to respond to their clients' needs in ways that are more helpful to a client's psychological processes and emotional needs.

Clinicians and other health care providers will inevitably experience issues related to sexuality with their clients at some point in their careers. How therapists react to and handle dialogues related to sexuality in a therapeutic setting is likely to influence her or his choices of interventions and treatment methods which, in turn, may directly affect therapeutic outcomes and the overall well being of those seeking treatment. While professionals in the mental health field agree on the importance of appropriately addressing issues related to sexuality, most clinicians are insufficiently trained to do so because there is an absence of clinical training on the topic of human sexuality within graduate programs (Harris & Hays, 2008; Bidell, 2005; Weerakoon, Sitharthan, & Skowronski, 2008). This study examines to what extent the human sexuality training offered by Smith SSW prepares clinicians to address the sexuality related issues that arise in a clinical setting.

A therapist's willingness to engage in dialogue about a client's sex life may be very different than a therapist's willingness to addressing sexual feelings that may arise within the

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therapeutic relationship. In addition to exploring the relationship between education and a clinician's comfort in addressing issues of sexuality with clients, this study also explores a therapist's willingness and ability to effectively detect and address erotic transference and counter transference. For the purposes of this study, erotic transference is defined in a psychodynamic context as being a reenactment of unresolved internal conflict that presents itself within the therapeutic relationship for resolution and produces intense sexual feelings on behalf of the client or the clinician. By applying a psychodynamic framework to sexual feelings that may come up for a client or a clinician in a therapeutic setting, a therapist has the opportunity to enhance a client's self-understanding, provide useful therapeutic feedback, help a client recover from trauma, increase a client's ability to avoid harmful circumstances and assist a client in his or her ability to engage in more satisfying relationships. A therapist's willingness to address sexual feelings can help clarify boundaries for the therapeutic relationship and establish a safe and effective therapeutic environment.

The meaning that individuals derive from sexuality and sexual expression vary greatly and is based on individual experiences within a larger social construct. For some individuals, sexuality is linked to procreation and reproduction. These individuals may best understand the role of sexuality as being that of a biological function which serves only to generate offspring. Others may link sexuality to feelings of love and attraction. These feelings of love and attraction may be applied to a single monogamous relationship that lasts a life-time; serial monogamy, which is defined as several long-term romantic relationships in succession; or polyamorous relationships, which is defined as a relationship in which individuals maintain simultaneous love relationships with multiple consenting partners. Individuals may apply spiritual principles to their expressions of sexuality, such as those who observe Tantric spiritual practices. Some

express sexuality through consensual erotic power exchange and role playing, and some individuals may subscribe to sexual ideologies which emphasize physical pleasure that is not reliant on feelings of romantic attachment toward those with whom individuals are sexually engaged with. The construct of sexuality varies for each individual; therefore it is essential for a therapist to understand sexuality from a client's perspective as opposed to assuming that a single definition can be applied as a universal standard.

Human sexuality training can offer a clinician insight regarding how cultural, gender, and societal roles may contribute to a client's perspective about relational roles, sexual identity, and core beliefs. Clinicians may gain important information about how their own personal attitudes, beliefs, and assumptions about sexuality may influence their work with their clients. The opportunity to gain a more complete understanding of a client's experiences and perceptions is reduced if a clinician is unable or unwilling to address human sexuality in a clinical setting.

While many graduate social work programs offer clinical training in the assessment and treatment of sexual trauma, abuse, and victim-victimizer relationships in general, few programs require students to participate in an in-depth human sexuality course. Smith SSW offers a course in human sexuality as an elective option and offers other elective classes that include components of human sexuality education but does not require students to include this course as a mandatory element of training. This study seeks to examine the extent to which courses offered at Smith SSW during the years 2000 and 2009 have prepared alumnae to handle sexuality related dialogues with their clients.

The purpose of this study was to examine the relationship between the human sexuality education of Smith SSW graduates and their comfort level in addressing sexuality with clients. Through a mixed methods research design, clinicians who graduated from Smith SSW between

the years of 2000 and 2009 were assessed for their personal level of comfort in addressing sexual issues with clients and were asked to what extent their education at Smith SSW enabled them to apply theoretical frameworks and interventions to the sexuality related issues that their clients may have presented.

The following chapters discuss various factors which may affect a therapist's ability to comfortably address clients' sexuality concerns. The proceeding chapter offers a literature review that details theoretical perspectives and social constructs of human sexuality. The chapter provides an overview of previous research which examined the relationship between human sexuality training and the comfort of mental health care and allied health care providers in having discussions with their clients about sexuality. After the literature review, a presentation is offered which details the methods and findings of the research used to examine the relationship between human sexuality training and Smith SSW graduates' comfort in having sexuality related discussions with clients. Finally, a conclusion based on this research is offered which provides a summary of data results, discusses the limitations of this study, includes implications for Smith SSW, and offers recommendations for further study development.

CHAPTER II

Literature Review

Sexuality can be viewed as a positive avenue for self expression and relational satisfaction. A statement by the World Health Organization may best summarize the definition of sexuality in the statement, "Sexual health is the integration of the somatic, emotional, intellectual, and social aspects of sexual well-being, in ways that are positively enriching and that enhance personality, communication, and love." (World Health Organization, 1995). Sexual expression involves internal concepts relating to the development of emotional and psychological constructs. Sexuality involves behaviors, attitudes, and emotional expression and, like any other human expression, is influenced by unconscious and conscious motivations. By conceptualizing sexual wellness as a vital aspect of the human psyche, as opposed to a taboo topic to be avoided, therapists may gain a more holistic understanding of their clients. However, many mental health professionals feel ill-equipped to address issues of sexuality with their clients and researchers indicate that this is due, in part, to a lack of clinical training pertaining to human sexuality (Harris & Hays, 2008; Bidell, 2005; Weerakoon et al., 2008).

While many graduate social work programs offer clinical training in the assessment and treatment of sexual trauma, abuse, and victim-victimizer relationships in general, few programs require students to participate in an in-depth human sexuality course. Smith SSW offers a course in human sexuality as an elective option and incorporates elements of human sexuality information in other electives such as gender studies, LGBTQ identity, and electives pertaining to boundaries and ethics of the profession, but does not require students to include

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comprehensive training in human sexuality as a mandatory component of degree requirements. Without this training, clinicians run the risk of misinterpreting and mishandling sexuality related discourse. In addition, they may address sexuality and sexual issues in ways that may be damaging to a client's psychological processes and emotional needs. Without training, clinicians may respond to sexuality related material in an unethical manner, thus jeopardizing their careers.

This chapter begins by reviewing the theoretical perspectives of psychodynamic and cognitive behavioral therapy (CBT) as they pertain to human sexuality. An examination of such frameworks is intended to provide a better understand the current clinical approaches to addressing sexuality in a therapeutic setting. Many clinicians are trained in these specific theoretical schools of thought, therefore it is important to examine how these theories conceptualize human sexuality and how these theories can potentially influence the degree to which clinicians feel comfortable with having clinical discussions about sexuality.

Other important considerations with regards to clinicians' comfort with having sexuality related dialogues with clients are the social constructs that define human sexuality. Various cultural norms are likely to influence a therapist's level of comfort with the subject of human sexuality. Current social scripts based on gender, race, and marginalized populations are pervasive in our American culture. Therefore an overview of some of the current social constructs of sexuality follows.

Finally, the remainder of this chapter includes a review of research that specifically examines the extent to which mental health clinicians and allied healthcare workers feel comfortable with discussing sexuality with clients. Current researchers indicate that there is a positive correlation between human sexuality training and an increased comfort level of clinicians to address their client's sexual concerns.

The subject of human sexuality encompasses a broad spectrum of attitudes, beliefs, and perspectives, and there are many factors that influence an individual's concept of human sexuality. Social constructs influence both the clinician's and the client's core beliefs about sexuality. Theoretical schools of thought provide a framework for clinical interventions. Basic human sexuality training may assist clinician's in their efforts to understand the experiences of their clients and provide effective treatment that regards sexuality as one of many important components of the human psyche. However, researchers have noted that addressing a client's sexual well-being is largely avoided by clinicians (Anderson, 1986; Daines, 1992; Daines & Perrett, 2000; Haboubi & Lincoln, 2003; Reissing & Giulio, 2010). This study seeks to identify whether education is a factor in the level of comfort that Smith SSW alumnae have with addressing sexual issues with their clients.

The Social Construction of Sexuality

Gender roles. When developing a framework for addressing sexuality in clinical practice, it's important to consider the long-standing social norms that have dominated western culture throughout history because gender based social norms and sexual stereotypes are still pervasive factors in individual sexual expression and conduct today. By way of the Married Women's Property Bill of 1856, the idea of sexual economics was introduced (Basch, 1986). In the 19th century, social regard for women was one of subordination to men. Marriage was a power based relationship in which the woman was forced into economic dependence on men. Marriage laws were skewed in that the use of sexual force was recognized by the law as rape in all cases, except for marriage (Jackson, 1994). The implications were that, through marriage, men purchased the "right" to utilize a woman's sexuality in any way that satisfied his specific self interest, regardless of her desires or needs (Jackson, 1994; Mill, Mill, & Taylor, 1994).

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Many social activists equated a woman's status within the context of marriage as being equivalent to prostitution and slavery (Jackson, 1994; Mill et al., 1994). The 19th Century social reformist, Charlotte Perkins Gilman openly classified marriage as a market in which the only commodity that women had was their sexuality (Jackson, 1994). Civil rights reformists asserted that marriage was an economic trade in which the entire basis of the marriage relationship was based on a man's ability to force women into trading sex for money by virtue of economic dependence. The assertion was that the only leverage a woman had in her livelihood through marriage was her sexuality (Jackson, 1994).

In the 1960s, social paradigms regarding the role of female sexuality were confronted and debated publically. As a result of the invention of birth control such as "The Pill", a social conversation developed regarding the fact that women enjoyed sex and had sexual needs and desires in the same way that men do. This development meant that women had the ability to have sexual experiences independent of marital status without fear of unwanted pregnancy. Books such as "Sex and The Single Girl" (Brown, 1962) and "The Feminine Mystique" (Friedan, 1963) sought to define female sexuality as an entity unto itself, as opposed to being dependent on a man's facilitation. In her book, "Sex and the Single Girl", Helen Gurley Brown normalizes the taboos that were present in the conceptualization of feminine sexuality by saying, "Perhaps you will consider the idea that sex without marriage is dirty…your moral code is your business…sex was here a long time before marriage...It isn't some random piece of mischief you dreamed up because you are a bad, wicked girl" (Brown, 1962).

Despite the political and social progress that has been made over the past few centuries in reshaping gender biased sexual norms, researchers indicate that gender-based power dynamics still influence sexual relationships and behaviors (He, Tsang, Zou, & Wu, 2010; Higgins,

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Trussell, Moore, & Davidson, 2010; McGuire & Barber, 2010; Mollborn & Everett, 2010; Stulhofer, Busko, & Brouillard, 2010). In a recent study that examined social scripts and sexuality, Kim, Sorsoli, Collins, Zylbergold, Schooler, and Tolman (2007) conducted a systematic analysis of television programs for sexual content and determined that television was a major source in which gendered sex roles were learned by teenagers. The authors highlighted the social dominance theory in that through television social scripts, males are taught that they are in a position of power and should actively pursue sexual relationships, thus treating women as sexual objects. The social scripts teach males to experience their sexual feelings as uncontrollable, thereby males are unable to set sexual limits. This social script instructs females that they are in a subordinate and sexually passive position, denying their own sexual desires in order to focus on fulfilling the male's sexual needs. In the heterosexual script, the female must appear to be sexually chaste and able to set sexual limits for men (Kim, et al., 2007). These social roles do not allow for women to prioritize their own sexual desires and encourage men to define their masculinity based on their sense of sexuality. The heterosexual script does not allow for homosexual identification, nor does it allow space for women to explore their own feelings of sexuality apart from that of satisfying men. These culturally engrained sexual scripts can present many challenges for the therapists and their clients. A therapist's willingness to discuss sexuality and explore these scripts with their clients can increase a client's self esteem and address attitudes that may be relationally defeating.

Racial constructs and sexuality. Those who are not among the racially dominant American culture are also faced with a unique set of social stressors that directly influence their sexual health and well-being. Researchers recently discovered that Latino and African American males were less likely to seek sexual and reproductive health care than white men and women (Kalmuss, Armstrong, Franks, Hecker, & Gonzalez, 2008). Men, in general, are reluctant to seek sexual health care and are therefore less likely to initiate dialogue regarding sexual health needs. This reluctance negatively affects their sexual health outcomes as well as the sexual well being of their partners. In a study focused on cultural factors that influence Latino women's sexual behavior, researcher Christina Villarreal (2004) noted that participants with higher acculturation levels expressed higher levels of sexual comfort and were significantly more likely to assert their sexual health needs, such as condom use, with their sexual partners. Villarreal (2004) also found that participants with lower acculturation were significantly more likely to have fear of sexual coercion and abuse, and subscribed to more traditional gender role beliefs. She concluded that acculturation was directly linked to the psychosocial factors that contribute to sexual health decision making and sexual behavioral among Latino women (Villarreal, 2004).

Sexuality and marginalized populations. The parameters of sexuality are largely defined by social constructs and cultural expectations. Social constructs of sexuality, sexual taboos, and sexual norms within a given culture can affect one's level of vulnerability to coercion, assertiveness, level of anxiety, partner communication styles, and overall sexual satisfaction. Societal and cultural attitudes about sexual expression vary based on age, gender, race, educational, and financial status (He et al., 2010; Higgins et al., 2010; McGuire & Barber, 2010; Mollborn & Everett, 2010; Stulhofer et al., 2010).

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For example, the need for positive sexual expression amongst population groups such as those who are cognitively or physically impaired has been largely ignored by heath care professionals (Valenti-Hein & Dura, 1996; Berkey, Perelman-Hall, & Kurdek, 1990; Guldin, 2000). Researchers express the need for these previously ignored groups to define their own sense of sexuality, even as they face other challenges of daily living and optimal functioning due to their mental or physical limitations. However, these same researchers note that clinicians, aides, mental health personnel, medical professionals, and social peers are not providing the support necessary in order for these groups to gain a sense of sexual autonomy and positive regard for sexual expression (Valenti-Hein & Dura, 1996; Berkey et al., 1990; Guldin, 2000).

These general societal constructs influence a clinician's perceptions of sexuality, including concepts pertaining to gender roles, sexual deviance, and sexual expression amongst marginal populations. Dominant cultural attitudes about sexuality continue to be extensively communicated through media, music, fashion, and government legislation. Social and sexual scripts include expectations based on gender, race, body image, and socioeconomic status, among other factors. Clinicians are not immune to these heteronormative sexual scripts and, without proper training, are likely to respond to their clients with potentially damaging attitudes that seem to be pervasive in our culture. These dominant attitudes may impede a clinician's ability to provide culturally sensitive care. In order to provide culturally competent mental health care, it is necessary for a mental health clinician to develop an understanding of meanings of sexuality in the context of their client's culture. Clinician's with no training in human sexuality may act on assumptions and preconceived notions that pathologize and unintentionally harm their clients.

Theoretical Conceptualizations of Sexuality

  Psychodynamic views of sexuality. Psychodynamic theory encompasses the interplay of motivational forces as they influence the expression of mental processes. Psychodynamic therapy encourages exploration and discussion of the full range of a patient's emotions and behaviors and the underlying factors that contribute to these emotions and behaviors. By using psychodynamic interventions, a therapist can help the patient in uncovering feelings that the patient may not initially be able to recognize. Psychodynamic therapy places heavy emphasis on both adaptive and maladaptive aspects of an individual's personality and self-concepts. Many interventions are utilized in the context of attachment relationships, ego-functioning, and object-relations theory. Sexuality can be thought of as interactions that are based on emotions and inner concepts of self (Berzoff, 2010; Berzoff, Flanagan & Hertz, 2008; Shedler, 2010). Freudian theory initially emphasized the psychological processes as being related, in part, to sexuality and destructiveness (Green, 1995). As psychoanalytic theories evolved into psychodynamic theories, the emphasis of sexuality was minimized. The minimization of sexuality in psychodynamic practices has served to allow for other components of theory to address unconscious factors that are independent of sexuality. However, in recent years, the sexual component of human behavior seems to have been altogether eliminated as a viable aspect of psychodynamic exploration in clinical practice.

  The phenomenon of erotic transference. One aspect of psychodynamic theory, erotic transference, provides a framework for the conceptualization of sexual feelings that may arise for either the client or the clinician during treatment. Many theorists view erotic transference as a manifestation of pre-oedipal, oedipal, or self object issues (Book, 1995; Stirzaker, 2000). A therapeutic relationship can often mirror the parent/child relationship. In this context, it can be useful to understand erotic transference as a reenactment of unresolved internal conflict that is

presenting itself within the therapeutic relationship for resolution. By addressing erotic

transference as a component that is associated with previous relationships with significant people

in a client's life, the emphasis of the transference is no longer placed solely on the therapist and a

client may feel safer in their exploration of various issues related to the transference. In order to

accomplish this, a therapist must first be comfortable in his or her ability to interpret the

transference, explore the latent meaning of the transference, and identify the transference as a

representation of pre-oedipal, oedipal, or self object issues (Book, 1995; Stirzaker, 2000).

Training and education about concepts related to erotic transference can help a clinician gain the

confidence needed to address an issue that, if otherwise ignored or avoided, may result in

unethical interactions between a therapist and her or his client.

A clinician's ability to detect and address erotic transference effectively can be a

tremendous asset to the client and assist the clinician in avoiding unethical behavior toward their

clients. Recently, researchers have discovered that, due to absent or improper training about the

subject of erotic transference, many clinicians are unable to differentiate between inappropriate

sexual conduct and erotic transference (Book, 1995; Stirzaker, 2000). Many therapists are

reluctant to discuss incidents of erotic transference with supervisors or colleagues because of

embarrassment or shame associated with the emotional content pertaining to the transference.

Because of recent cases involving the sexual exploitation of clients, many clinicians attempt to

avoid the entire subject of erotic transference and they are unable to identify erotic transference

as a potentially fundamental part of the therapeutic relationship (Stirzaker, 2000).

Researchers Pope, Keith-Spiegel, and Tabachnick (1986) surveyed 585 APA registered

private practice psychotherapists (339 or 57.9 % men and 246 or 42.1% women) with an average

of 16.99 ($SD = 8.43$) years of clinical experience and found that 87% of respondents (95% of

men and 76% of women) had, on at least one occasion, been sexually attracted to their clients. While only 9.4% of men and 2.5% of women indicated that they had acted on their attraction, a large portion of respondents (63%) felt guilty, anxious, or confused about the attraction. Over half of the respondents (55%) indicated that they had not received any training concerning sexual or erotic transference, 24% indicated that they had received very little training, 12% indicated that they had received some training and only 9% reported that they had received adequate training or supervision on the subject. Pope et al., (1986) reported that those who had at least some graduate training on the subject were more likely to seek consultation (66%) than those who had no training (49%), $X^2(1, N = 474) = 12.92$, $p < .001$. The authors indicate a necessity to incorporate education on the topic into standard professional training instead of relegating the topic to a limited one-time lecture set apart from standard curriculum .

Cognitive behavioral views of sexuality. Several authors make distinctions between emotional insight and intellectual insight (Firestone, Firestone, & Catlett, 2006). In the book, *Sex and Love in Intimate Relationships,* Firestone, Firestone, & Catlett (2006) describe emotional insight as having characteristics that resonate at a deep and personal level which leads to change, whereas intellectual insight maintains a narrow focus on cognitive thought processes and reasoning. The authors explain that this is one reason why intelligent and psychologically minded people are capable of providing the reasons for their difficulties, yet still find that they continue to be incapable of overcoming those difficulties (Firestone et al., 2006). While cognitive behavioral therapy (CBT) provides effective strategies for restructuring thought processes to improve communication and resolve problematic physiological sexual functioning and is widely used in therapeutic interventions, these interventions do not necessarily regard sexuality as a representation of the inner psyche. Instead, CBT seems to address sexuality only as

it applies to maladaptive habits of rational thinking (Ellis, 1962; Lantz, 1978; Walsh, 2008). Through their work with clients, Firestone et al. (2006) have determined that an individual's attitude toward sex is usually reflected in his or her level of vitality, overall appearance, and expressions of tenderness and affection. Furthermore, these authors indicate a correlation between one's sexual desire and his or her overall concept of life. In other words, those who presented with positive concepts of sexuality also had an increase in positive attitudes about life in general, whereas those who had diminished or inhibited sexual desire also had less enthusiasm for life (Firestone et al., 2006). It seems safe to conclude that one's sense of sexuality is related to one's sense of self and there is need to include sexuality as an avenue to be explored within a therapeutic setting.

Current Research on Clinician Comfort with Discussing Sexuality in Clinical Practice

In recent years, therapists seem to have lost an important avenue of psychological discovery by avoiding discussions about sexuality (Knafo, 2010; Green 1995). Additionally, the psychotherapeutic community has confined certain terms and concepts, such as perversion, promiscuity, submissiveness, dominance, control, seduction, and gender by associating these terms strictly to sexual behavior. In so doing, the psychotherapeutic community has restricted its ability to understand the full nature of these concepts as they apply to conditions beyond sexual practices (Stein, 2005; Green, 1995).

Several researchers conclude that many clinicians in the mental health field are ill prepared to effectively engage in sexuality related discussions with clients. These researchers associate this lack of preparation with a lack of professional training (Harris & Hays, 2008; Bidell, 2005; Weerakoon et al., 2008). In a study of allied health care professionals' comfort level in discussing sexuality with clients, Weerakoon et al., (2008) requested participation from

106 health professional undergraduate students, such as occupational therapists and physical

therapists who had enrolled in a web-based human sexuality course that ran for a semester of 13

weeks. The course included streaming videos, group discussions, and written content intended to

increase competencies in granting permission to clients to have sexual concerns discussed,

providing limited information on sexuality related issues, and providing specific suggestions

regarding these issues. Students were asked to answer a 5-point Likert-scale questionnaire before

and after participation in the course to assess their anticipated comfort level in a range of clinical

circumstances that had sexual connotations. The questions ranged from general questions such

as, "how comfortable do you feel answering a client's sexually related questions?" to more

specific questions that address issues such as sexual orientation, sexually related concerns of

physically handicapped clients, and specific sexual practices of clients.

Of the 106 students enrolled in the course, 102 (96%) responded to the pre-course

questionnaire and 62 students (58.5%) responded to the post-course questionnaire. Participants

indicated a significant increase in their willingness to address their client's sexual issues after

participating in the human sexuality course ($t = 2.394$; $df = 162$; $p = 0.018$). The authors of the

study suggest a need for intensive sexuality education for health professional students in order to

provide holistic health care to their clients (Weerakoon et al., 2008).

In conducting a study that focused on mental health counselors' ability to address a

client's sexuality and sexual orientation, Mark Bidell (2005) used 7-point Likert-scale

instruments that were based on concepts of cultural competency in his creation of the Sexual

Orientation Counselor Competency Scale (SOCCS). Bidell (2005) defined sexual orientation

counselor competency as "attitudes, knowledge, and skills that counselors need to provide

ethical, affirmative, and competent services to LGBT clients" (p. 268). The instruments included

items which measured respondent's awareness of their own attitudes, world views, and cultural history as well as skills and knowledge about specific marginal populations.

The 312 participants of the study were comprised of 235 women and 77 men from 16 university counseling programs and centers across the United States. The sample included 47 (15.1%) undergraduate psychology students; 154 (49.4%) master's-level counseling students enrolled in a CACREP-accredited counselor education program; 62 (19.9%) doctoral-level students enrolled in either a CACREP-accredited program or an APA approved counseling internship program; 49 (15.7%) doctoral-level educators or supervisors working at either CACREP or APA approved education programs. Bidell (2005) found that those who had higher levels of education scored significantly higher overall, $F(3, 308) = 75.10$, $p < .001$. Bidell (2005) indicated that mental health counseling students consistently reported that their training had not prepared them to work competently with the sexual issues of marginal populations. Because of social biases that continue to label the LGBT community as immoral and perverted, Bidell (2005) suggested that clinicians develop an awareness of their own attitudes, assumptions, and biases regarding same-sex orientations and sexual experiences.

In a similar study that evaluated the comfort and willingness of Marriage and Family Therapists (MFT) to discuss sexuality with clients, Harris and Hays (2008) explored factors such as an MFT's perceived sexual knowledge, the amount of clinical training and education, and their personal comfort level with the subject of sexuality. Participants consisted of 175 AAMFT affiliated therapists (65 male, 110 female) who had previous exposure to family systems theory and sexuality education, had a minimum of 100 direct client contact hours, and 200 supervision hours. Thirteen respondents reported that they had received certification as a sex therapist. The authors indicated that those who had been certified as a sex therapist were more likely to initiate

discussions about sexuality with their clients ($M = 5.4$; $SD = .85$) than those where were not certified ($M = 4.6$; $SD = 1.3$), t (137) = -2.15, $p < .05$.

Using a path analysis model, the authors evaluated the relationship between the independent variables of sexuality education and supervision, clinical experience, perceived sexual knowledge and sexual comfort and the dependent variable of sexuality discussions with clients. Harris and Hays (2008) reported that the independent variables of education and supervision explained 48% of the variance in therapist comfort with sexuality issues, and had a significant direct effect on the dependent variable. The authors' hypothesis that MFTs with graduate-level sexuality education and supervisory experience would be more comfortable with sexuality related issues than those without specific graduate course work on the subject was supported by their study.

The authors noted a surprising lack of existing data on the subject of therapists' comfort dealing with sexuality related discussions, given the large volume of literature on treatment-specific sexual topics and given the high likelihood that most therapists will be presented with clients' sexuality related concerns at some point in their careers. The authors further indicate that little data have been published regarding how a therapist can effectively address the sexual concerns of their clients and that human sexuality training opportunities for therapists remain minimal (Harris & Hayes, 2008).

Need for Further Research

While various state licensing boards and healthcare agencies are beginning to regard human sexuality as a significant factor that requires training for mental health clinicians, researchers suggest that many clinicians still remain untrained in this area. Clinicians who are left untrained in human sexuality concepts may be more likely to avoid the topic as a result of

their own emotional discomfort. Clinicians with no human sexuality training may be increasing the risk of harm to their clients, thereby opening themselves up to negative legal and professional consequences. More research is necessary to discover how much training is necessary in order for clinical social workers to feel comfortably equipped to deliver competent mental health care where issues of sexuality arise. It is also necessary to explore whether graduate level courses that include limited aspects of human sexuality as a component of the coursework are effective enough to increase a clinician's comfort level with discussing sexual issues with their clients.

The social construction of sexuality may be a barrier to therapeutic work in areas concerning sexuality because many clinicians may reflect the dominant cultural biases of heteronormative social scripts. It may be beneficial to examine whether factors such as gender, race, and sexual orientation play a role in a clinician's comfort and willingness to engage in discussions about sexuality with their clients.

Theories from both a psychodynamic framework and cognitive behavioral framework are beginning to incorporate aspects of sexuality but practice models are still conceptually limited in scope. These general models may not address human sexuality thoroughly enough for a therapist to develop effective therapeutic interventions. While researchers indicate the importance of addressing the emotional and psychological needs of a sexually diverse population, additional research is needed to investigate the extent to which the current theoretical education offered by graduate-level institutions are preparing clinical social workers to deliver culturally competent mental health care to diverse populations.

While studies exist regarding the comfort of sexuality dialogues with clients amongst allied health care professionals and MFTs, there is minimal empirical data published pertaining to clinical social workers. To date, no published material specifically pertaining to the comfort

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and willingness of social work graduates to address sexuality with their clients has been found. Since clinical social workers are as likely to be engaged with clients for whom sexuality topics are relevant, more research on the comfort and skills social workers have in this area is needed. Smith SSW has a long-standing reputation for delivering high quality education to its students. There remains a need for further research to determine which classes over the past 10 years, if any, have assisted Smith SSW Alumnae in their efforts to comfortably engage in dialogue with their clients about sexuality. The aim of this study is to determine to what extent formal human sexuality education influence whether or not Smith graduate clinical social workers feel comfortably equipped to discuss sexuality with their clients.

CHAPTER III

Methodology

The purpose of this study was to examine the relationship between the human sexuality education of Smith SSW graduates and their comfort level in addressing sexuality with clients. Clinicians who had graduated from Smith SSW were assessed for their personal level of comfort in addressing sexual issues with clients and were asked to what extent their education at Smith SSW had enabled them to apply theoretical frameworks and interventions to the sexuality related issues that their clients may have had. Clinicians were asked about any additional training that they had received regarding human sexuality in order to consider if such training had influenced the clinician's ability to comfortably address sexuality related issues in a therapeutic setting.

Instruments

A mixed methods research questionnaire (see Appendix A) that included both open-ended and scaled survey items was administered through the secure internet survey tool, surveygizmo.com. This survey included demographic questions about gender, racial, and age identification. The quantitative aspect of the research was designed to examine the current level of clinicians' comfort with addressing sexual issues with their clients and utilized a Likert-scale design. The survey questions were developed in consideration of two different questionnaires which had high internal test reliability when used in similar studies. The first study evaluated the comfort of 175 clinical members of the American Association for Marriage and Family Therapy in discussing client sexuality (Harris & Hays, 2008). The Harris & Hays study included a scale of perceived sexual knowledge which had a Cronbach's alpha .85 test reliability; a sexual

comfort scale which had a Cronbach's alpha .86 test reliability; and a sexuality discussions scale which had a Cronbach's alpha .90 test reliability. The second study utilized a questionnaire to evaluate 106 allied health professional students' comfort level for discussing sexuality related topics before and after taking an on-line human sexuality course (Weerakoon et al., 2008). The Weerakoon, Sitharthan, & Skowronski study reported a Cronbach's alpha of .89. The surveys used in these studies were not specifically included in this study's questionnaire because the questions did not cover the spectrum of sexuality topics to the extent desired, nor did they include questions related to the phenomenon of erotic transference. However, both of these studies were used as a basis in the development of questions asked in this study's survey.

Data was collected between January 25, 2011 and March 14, 2011 by means of a mixed method survey that was created by this researcher and managed through the internet survey program offered by surveygizmo.com. The questionnaire consisted of 6 sections of quantitative, Likert-scale questions and one qualitative section that consisted of three open ended questions.

The first section pertained to demographics and contained questions to identify gender, race, age, and respondents' understanding of his or her sexuality. The second section pertained to education and training and included questions about the year respondents graduated from Smith SSW and courses taken in graduate, undergraduate and continuing education programs that were specific to human sexuality. The third section addressed clinical practice and included questions about how long the respondents had been in clinical practice, how often respondents dealt with sexuality related issues in their practice, and to what extent they felt comfortable addressing sexuality related issues with their clients, supervisors, and colleagues. The fourth section addressed respondents' attitudes about sexuality in clinical practice and asked questions regarding personal views about the morality, ethics, and necessity of addressing sexuality with

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clients in a clinical setting. The fifth section of the survey investigated the comfort of respondents when addressing sexuality in a clinical setting and asked questions about the barriers to addressing sexuality, the frequency of including sexuality related questions in an assessment, and the level of insight into other biopsychosocial factors that asking sexuality related questions might provide for respondents. The sixth section of the survey addressed the phenomenon of erotic transference. This section defined erotic transference as a reenactment of unresolved internal conflict that presents itself within the therapeutic relationship for resolution and produces intense sexual feelings on behalf of the client or the clinician. Questions in this section asked about respondents' ability to detect erotic transference, the frequency of erotic transference encounters, and about respondents' views on the usefulness of erotic transference within a therapeutic relationship.

For the purposes of this study, this researcher attempted to develop scales to measure specific characteristics of those who participated in the survey. This researcher attempted to include a sexuality education scale, a sexuality attitudes scale, a sexual comfort scale, and an erotic transference scale. Due to the formatting and the limited number of questions included in the scales, analysis results were inconsistent for some of the scales and a decision was made to evaluate scores of the individual questions for which scales could not be created.

Sexuality education measures. Questions pertaining to sexuality education assessed the extent of human sexuality training that Smith Alumnae had received at the time of participation in the survey. Participants were asked to indicate the number of human sexuality classes or seminars taken before, during, and after their education at Smith SSW to determine if the amount of classes had an effect on participants' comfort and attitude about sexuality related discussions. Participants were asked to describe the titles of courses that they felt equated with or contained

significant elements of human sexuality training to evaluate how participants conceptualize human sexuality training.

Several of these questions were used to analyze differences in groups. Specifically, a question was asked regarding whether or not participants had taken a human sexuality course during their undergraduate, graduate, or post-graduate education. This question was used to establish two groups for comparison; those who had obtained human sexuality training and those who had not. Comparisons between these two groups were made to determine if there was a difference of comfort about discussing sexuality issues with clients, supervisors, and colleagues. Additionally, comparisons between the groups were made to determine if there was a difference of attitudes regarding sexuality. Comparisons between these two groups were made to determine if there was a difference in ability and comfort with detecting and addressing issues of erotic transference.

Sexuality attitudes. The sexuality attitudes scale included four questions about the respondents' views about the morality, professional ethics, necessity, and benefits to insight of having sexuality related discussions with clients. Respondents answered these questions by indicating either all of the time, more often than not, occasionally, rarely, and never. This scale used a reverse-order measurement and lower scores indicated a higher score in attitudes that regarded discussions of sexuality to be moral, ethical, necessary, and beneficial to insight. One question, question number 21, did not have the same format therefore the statistician reverse scored the question before running a Cronbach's alpha test. This scale had a Cronbach's alpha of .61, indicating adequate internal reliability.

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Sexuality comfort. Questions were developed to assess how comfortable respondents feel when addressing issues of sexuality under a variety of specific conditions. There were only three questions (questions 13, 14, 18) that had the same response format and there may have been other contributing factors for respondents' answers to question 18. With the inclusion of question 18, a Cronbach's alpha was only .595, which was not high enough to indicate internal reliability. After eliminating question 18 from the scale, a Cronbach's alpha of .794 was obtained. This researcher had concerns about using a scale that consisted of only two questions; therefore the questions were not developed into a scale.

Comfort with erotic transference. Questions were designed to determine the level of comfort and confidence of respondents dealing with the phenomenon of erotic transference. The five questions asked respondents to self-report the frequency of erotic transference encountered, the ability of the respondent to recognize and address erotic transference when it occurs, and the extent to which respondents view erotic transference as valuable to the therapeutic process. Respondents answered these questions by responding either all of the time, more often than not, occasionally, rarely, or never. Higher scores indicated a higher degree of comfort with addressing issues of erotic transference with a client. A scale was not developed from these questions, as the Cronbach's alpha was only .318.

Qualitative measures. In addition to the quantitative measures, respondents were asked qualitative questions which were used to determine which classes at Smith SSW, if any, assisted respondents in their ability to effectively address sexuality with their clients. Respondents were ask if any additional or supplementary training was received since graduating which may have enhanced their ability to address sexuality in a clinical setting. Respondents were asked for their feedback regarding what curriculum might be added or modified to assist future graduates in

their ability to address sexuality in clinical practice. Qualitative questions included in the survey asked: Which Smith SSW classes best prepared you to address sexual issues with your clients? What training outside of Smith SSW have you found effective in your ability to understand and address sexuality with your clients? What curriculum would you like to have had during your tenure at Smith that would have best prepared you to address sexuality with your clients?

The survey took approximately 5 to 15 minutes for respondents to complete. Data output was retrieved from a secure, password protected access source provided as a tool by surveygizmo.com.

Sample

This study limited the scope of respondents to those who had completed the Smith SSW graduate program between the years 2000 and 2009 in order to evaluate the current curriculum offered at Smith SSW. Further requirements for participation were that clinicians had to be working in a clinical setting for at least one year and had to be working with an adult population. The intention was to recruit 50 respondents to participate in a secure-internet based survey. To screen out respondents who did not qualify for this study, the criteria for participation was included in the initial recruitment contact and respondents were asked to confirm their eligibility on the welcome page of the survey before proceeding to the survey itself. Those who indicated that they did not fit the criteria were redirected to a page which informed them of their ineligibility and thanked them for their interest. Because the demographics of Smith SSW Alumnae vary in race, ethnicity, gender, sexual orientation, and age range, these components were not considered for inclusion or exclusion.

Recruitment

The recruitment process was initiated by placing a written request in the February edition of the Smith SSW Alumnae monthly newsletter entitled "In Brief". The request for participation introduced this researcher's role as a Smith SSW student, introduced my thesis topic, described the specific criteria for inclusion, contained a web-link to access the welcome page of the survey, and included this researcher's email address and phone number should any questions or concerns arise. The first written request contained an error in the survey web-link address; however, 11 respondents emailed this researcher directly to obtain the correct link and responded at the time of the initial request. A second notice was placed in the March edition of the newsletter with the correct link and an additional 79 respondents responded to the survey.

Ethics and Safeguards

A Human Respondents Review Application was submitted and approved by the Smith SSW Human Respondents Review Board in order to ensure that this study was of minimal risk to respondents and that data was handled in such a way as to protect the respondents' confidentiality (see Appendix B). The informed consent described the content and purpose of the study and informed respondents that there was no known risk to participation. The informed consent described the measures taken to ensure confidentiality, and included my contact information in the event that questions or concerns should arise (see Appendix C). All respondents included in the results of this study indicated that they had read and agreed to the terms of the informed consent by clicking on a button answering "yes" to the statement, "I agree to the terms and conditions of this study" before they were able to access the content of the survey. Respondents who did not agree to the terms of the informed consent clicked on a button that stated "no" to the statement and were redirected to a page indicating that they did not qualify for the survey (see Appendix D).

This survey was anonymous and did not contain any identifying information. Any identifiers that respondents may have included in their answers to the open-ended questions were removed before analysis. Respondents were informed that they had the right to withdraw from the study before they submitted it simply by leaving the site. Because of the anonymous nature of this study, it was not be possible for respondents to withdraw from participation once they had completed and submitted the survey because it would have been impossible to identify any particular survey.

Because of the anonymous and voluntary nature of the survey, the respondents should not have felt coerced into participation. Since the respondents were social workers, no referrals were given, but respondents were provided with resources for more information in the content area (see Appendix E).

Surveys submitted were only accessible to the researcher by password. On March, 14, 2011, all files were removed from the survey website and downloaded onto a portable media devise which was stored in compliance with federal regulations and research standards. After three years of storage, data will be destroyed. Should this researcher need to access the data after this three year period, the data will continue to be stored in a secure location and destroyed when it is no longer needed.

Data Analysis

Data collected from the surveys were cleaned of all identifying information before analysis begun on March 14, 2011. Raw data, coded data, and a code book were emailed to the Smith SSW staff statistician using excel and SPSS databases for analysis.

A total of 108 respondents responded to the request for participation. One respondent did not qualify for the study and 17 respondents exited the survey without completion. These responses were removed from the data before analysis. The remaining 90 responses were analyzed.

Frequencies were run through both surveygizmo.com and through the staff statistician for all quantitative survey questions. Both frequency outputs generated the same frequencies, verifying accuracy of information. A multiple response analysis was generated to evaluate the multiple response answers. T-tests were used to evaluate the difference between those who reported having taken a human sexuality class and those who had not in areas of comfort level and attitudes. Additionally, Chi Square tests were used to determine if those who took human sexuality classes at Smith College would be more likely to seek out additional CEUs in human sexuality training than those who had not.

Crosstabulation tests and Spearman's Rho correlation tests were used to determine the relationship between the amount of human sexuality training and comfort with discussing sexuality with clients, attitudes toward sexuality, and comfort with erotic transference. These same tests were used to determine the relationship between clinical experience of respondents and their comfort and attitudes towards sexuality and comfort with erotic transference. Crosstabulation tests were used to determine if there was a relationship between those who reported having taken human sexuality classes at Smith and the specific classes that were taken.

Additionally, crosstabulations were used to determine if there was a relationship between the year in which respondents graduated from Smith SSW and the specific classes named by respondents as being related to human sexuality.

Qualitative data were manually coded and organized into categories or themes for analysis. This researcher evaluated individual responses and noted duplicate responses among the sample group. This researcher then grouped similar responses into categories or themes. The majority of responses included one to two categories or themes although a few responses included three or four. There were 10 categories noted for the open ended question pertaining to classes at Smith SSW that contained human sexuality components. There were 12 categories noted for the question pertaining to which Smith SSW classes best prepared respondents to address issues of sexuality. There were five themes associated with the question pertaining to outside experiences that contributed to respondents' level of comfort with addressing sexuality. There were 8 themes associated with the question pertaining to respondents' suggestions regarding Smith SSW curriculum.

CHAPTER IV

Findings

Practicing mental health clinicians who had graduated from Smith SSW between one and ten years ago were asked to respond to an on-line survey in order to evaluate the relationship between human sexuality training and the level of comfort the clinicians have in discussing sexuality issues with clients. The remainder of this chapter contains the findings of the survey and includes content which describes the demographics, the level of human sexuality training, and clinical experience of the sample population. Additionally, in this chapter, I will present finding related to respondents' sexual attitudes, comfort with detecting and addressing erotic transference, as well as consistent themes related to the range of classes that respondents associated with human sexuality training.

Demographics

As indicated in Table 1, the majority of the respondents were Caucasian females. Only 3.3% of respondents identified as African American; 3.3% identified as multi-racial and 2.2% reported their racial identity as Asian. A very small percent of respondents identified as male (8.9%) and 1.1% identified as transgendered. The remainder of respondents (90%) identified as female. The majority of respondents were between the age of 30 to 35 years old and the mean age of participants was 32.8 years old ($SD = 5.74$, $N = 90$). The distribution of participant graduation dates generally ranged from between 6.7% to 15.7% for each year with the most number of graduates completing the Smith SSW program in 2007 (15.7%), as shown in Table 2.

Table 1

Demographics of Sample

Demographic	Description	Frequency	Percent	Valid Percent	Cumulative Percent
Gender	Male	8	8.9%	8.9%	8.9%
n = 90	Female	81	90.0%	90.0%	98.9%
	Transgender	1	1.1%	1.1%	100%

Demographic	Description	Frequency	Percent	Valid Percent	Cumulative Percent
Race	African American	3	3.3	3.4	3.4
n = 89	Asian	2	2.2	2.2	5.6
	White	81	90.0	91.0	96.6
	Multi-racial	3	3.3	3.4	100.0

Demographic	Description	Frequency	Percent	Valid Percent	Cumulative Percent
Age	24-29	12	13.3	13.3	13.3
n = 90	30-35	34	37.8	37.8	51.1
	36-49	17	18.9	18.9	70.0
	40-45	15	16.7	16.7	86.7
	46-50	3	3.3	3.3	90.0
	51+	9	10.0	10.0	100.0

Table 2

Graduation Year of Sample

$n = 89$	Graduation Year	Frequency	Percent	Valid Percent	Cumulative Percent
	2000	8	8.9	9.0	9.0
	2001	6	6.7	6.7	15.7
	2002	6	6.7	6.7	22.5
	2003	8	8.9	9.0	31.5
	2004	7	7.8	7.9	39.3
	2005	10	11.1	11.2	50.6
	2006	10	11.1	11.2	61.8
	2007	14	15.6	15.7	77.5
	2008	8	8.9	9.0	86.5
	2009	11	12.2	12.4	98.9
	phd2001	1	1.1	1.1	100.0

Because of the varied distribution in graduation dates, the data were combined to reflect two groups: those who had graduated between the years 2000-2005 and those who graduated between 2006-2010. A Chi Square analysis was conducted to determine if there was a difference in human sexuality classes taken at Smith SSW by these two categories. No significant difference was found. The PhD student was regarded in the same manner as the other participants as this study sought to evaluate the overall graduate level education as it relates to a clinician's comfort in addressing sexuality with clients.

Extent of Human Sexuality Training

Approximately half (51.7%) of the respondents stated that they had taken either an undergraduate or graduate level human sexuality courses (see Table 3). These courses could have been completed at institutions other than Smith SSW. More than half of respondents (56.7%) stated that they had not pursued any continuing education pertaining to human sexuality (see Table 3). A second question asked participants about their educational experiences at Smith SSW. While none of the participants indicated that human sexuality courses were taken as a mandatory requirement at Smith, about half of the participants (58.2%) stated that they had received some form of human sexuality training at Smith, either as an elective class or as a component of a class taken at Smith (see Table 3). As shown in Table 4, the average number of classes with human sexuality content that respondents had taken was 1.4 classes ($SD = 0.77$). When asked to specify which Smith SSW classes provided human sexuality training, 16.4% of the respondents answering this question stated that they did not recall the name of the class that provided training and only 18.4% reported having taken a comprehensive human sexuality course. Thus, although almost half of the respondents indicate they had taken a graduate or undergraduate sexuality only a third of these took a class during their MSW studies. In fact, only

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10% of all respondents had taken a comprehensive sexuality course while enrolled in the Smith

School for Social Work. The remainder of the respondents indicated having human sexuality

covered as a topic within another course (see Table 5).

Table 3

Extent of Human Sexuality Training

Description	Training Received	Frequency	Percent	Valid Percent	Cumulative Percent
Undergraduate or graduate level	Yes	46	51.1	51.7	51.7
$n = 89$	No	43	47.8	48.3	100.0

Description	Training Received	Frequency	Percent	Valid Percent	Cumulative Percent
Smith training	Elective	25	27.8	29.1	29.1
$n = 86$	Class component	25	27.8	29.1	58.1
	Not covered	36	40.0	41.9	100.0

Description	Training Received	Frequency	Percent	Valid Percent	Cumulative Percent
CEUs	Yes	39	43.3	43.3	43.3
$n = 90$	No	51	56.7	56.7	100.0

Table 4

Total Human Sexuality Classes Taken

$n = 89$	Class Amount	Frequency	Percent	M (SD)
	Over 5	8	9%	1.4 (0.77)
	3 to 5	11	12.4%	
	1 to 2	49	55.1%	
	None	21	23.6%	

Table 5

Smith SSW Classes Containing Human Sexuality Training

$n = 49$	Class Name	Frequency	Percent	Valid Percent	Cumulative Percent
	LGBT identities	15	16.7%	30.6%	30.6%
	Human sexuality	9	10.0%	18.4%	49.0%
	Social work practice	8	8.8%	16.4%	65.4%
	Don't recall	8	8.8%	16.4%	81.8%
	Gender studies	3	3.3%	6.1%	87.9%
	Couples therapy	2	2.2%	4.1%	92.0%
	Sociocultural concepts	1	1.1%	2.0%	94.0%
	Child development	1	1.1%	2.0%	96.0%
	HIV education	1	1.1%	2.0%	98.0%
	Family dynamics	1	1.1%	2.0%	100.0%

Clinical Experience

Participants were asked about their clinical experience, including the number of years in practice and the extent of sexuality related issues they encounter in practice. The majority of the respondents indicated having between three and seven years of clinical experience (see Table 6) and the average years of clinical experience was 4.1 years ($SD = 2.25$). Most of the respondents (82%) reported dealing with sexuality related issues either more often than not or occasionally in a therapeutic setting (see Table 6). No significant correlations were found between years of clinical practice and the level of comfort participants felt discussing human sexuality issues with clients. This indicates that the level of comfort participants felt was not significantly influenced by the years of clinical experience they had.

Table 6

Extent of Respondents' Clinical Experience

Description	Years	Frequency	Percent	Valid Percent	Cumulative Percent
Years in practice	More than 10 years	9	10.0	10.0	10.0
$n = 90$	8-10 years	14	15.6	15.6	25.6
$M = 4.1$ (*SD* 2.25)	5-7 years	26	28.9	28.9	54.4
	3-4 years	26	28.9	28.9	83.3
	1-2 years	15	16.7	16.7	100.0

Description	Occurrences	Frequency	Percent	Valid Percent	Cumulative Percent
Works with sexually related issues	All of the time	1	1.1	1.1	1.1
	More often than not	34	37.8	38.2	39.3
$n = 89$	Occasionally	39	43.3	43.8	83.1
	Rarely	13	14.4	14.6	97.8
	Never	2	2.2	2.2	100.0

Relationship between Comfort and Training

Participants were asked about their understanding of their own sexuality (see Table 7). In all, 96.7% of respondents reported having a clear understanding of their own sexuality either all of the time (46.7%) or more often than not (50%). Only 1.1 % of respondents were still coming to understand their sexuality. Most respondents (84.4%) indicated that that they felt comfortable having discussions with their supervisors about sexual issues that arise in a clinical practice either all of the time or more often than not and 74.4% of the respondents indicated that they would feel comfortable discussing sexuality issues with colleagues either all of the time or more often than not (see Table 7).

Participants were also asked about how they approach discussions about sexuality with clients. Due to an oversight in the development of the survey, there was no direct question about respondents' level of comfort with discussing sexual issues with clients, however, several questions pertaining to how respondents approach these discussions with clients indicated the extent of comfort felt by respondents (see Table 8). Approximately one third of respondents (33.7%) stated that they always include sexuality related questions in an assessment as a standard of practice, and 44.2% of respondents stated that they initiate conversations about sexuality with their clients. The majority of respondents (83.1%) indicated that they felt that having sexuality related discussions with clients could provide valuable therapeutic insight into other aspects of their clients' lives either all of the time (24.7%) or more of than not (58.4%).

Table 7

Comfort with Sexuality Discussions with Supervisors and Colleagues

Description	Comfort Level	Frequency	Percent	Valid Percent	Cumulative Percent
Understands his/her own sexuality	All of the time	42	46.7	46.7	46.7
$n = 90$	More often than not	45	50.0	50.0	96.7
	Occasionally	2	2.2	2.2	98.9
	Rarely	1	1.1	1.1	100.0

Description	Comfort Level	Frequency	Percent	Valid Percent	Cumulative Percent
Discussions with supervisors	All of the time	22	24.4	24.4	24.4
	More often than not	54	60.0	60.0	84.4
$n = 90$	Occasionally	12	13.3	13.3	97.8
	Rarely	2	2.2	2.2	100.0

Description	Comfort Level	Frequency	Percent	Valid Percent	Cumulative Percent
Discussions with colleagues	All of the time	32	35.6	35.6	35.6
	More often than not	35	38.9	38.9	74.4
$n = 90$	Occasionally	20	22.2	22.2	96.7
	Rarely	3	3.3	3.3	100.0

Table 8

Comfort with Sexuality Discussions with Clients

Description	Comfort Level	Frequency	Percent	Valid Percent	Cumulative Percent
Assessment inclusion	All of the time	30	33.3	33.7	33.7
$n = 89$	More often than not	25	27.8	28.1	61.8
	Occasionally	24	26.7	27.0	88.8
	Rarely	8	8.9	9.0	97.8
	Never	2	2.2	2.2	100.0

Description	Comfort Level	Frequency	Percent	Valid Percent	Cumulative Percent
Initiates discussion	All of the time	38	42.2	44.2	44.2
$n = 86$	Only if trauma	22	24.4	25.6	69.8
	Client initiates	26	28.9	30.2	100.0

Description	Comfort Level	Frequency	Percent	Valid Percent	Cumulative Percent
Discussions provide therapeutic insight	All of the time	22	24.4	24.7	24.7
	More often than not	52	57.8	58.4	83.1
$n = 89$	Occasionally	15	16.7	16.9	100.0

The findings supported the hypothesis that respondents who had taken a human sexuality class in undergraduate or graduate school were more likely to feel comfortable discussing sexuality with clients than those who had not. Chi square tests were run to evaluate the relationship between whether respondents had taken an undergraduate or graduate human sexuality course and their approaches to sexuality in clinical work. There was a positive but weak significant correlation between the amount of human sexuality classes taken and responses stating that sexuality questions were used by participants in biopsychosocial assessments ($r_s =$ .274, $p = $ .010, two-tailed). This suggests that those with more human sexuality training are more likely to include human sexuality questions in an assessment. There was a significant difference in whether participants initiate sexuality related discussion by whether or not they had training, $t(84) = 2.016$, $p = $ .047, two tailed. Those with training had a lower mean ($M = 1.68$) than those without ($M = 2.05$). This indicates that those with human sexuality training are more likely to initiate sexuality related discussions with their clients than those without training.

The majority (83%) of respondents stated that having a discussion with clients about sexuality can provide valuable insight about other aspects of a client's biopsychosocial functioning either all of the time or more often than not. There was a notable decrease in responses to the question pertaining to barriers of discussing sexuality with clients with only 53 of the 90 participants responding. This may indicate a general discomfort amongst respondents with regards to examining specific barriers to discussions about sexuality. When asked what barriers might prevent clinicians from feeling comfortable having discussions about sexuality with their clients, the two most frequently reported barriers were lack of training (60.4%) and racial or cultural differences (43.4%) (see Table 9). Race and culture may be a good area of emphasis for sexuality education, as race and sociocultural concepts are influential to beliefs and

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views pertaining to sexuality. Additionally, fear of erotic transference was named as a barrier by 34% of respondents.

Table 9

Barriers to Discussing Sexuality with Clients

n = 53	Barrier	Response Count	Percent of Responses	Percent of Cases
	Not enough training	32	35.6%	60.4%
	Racial or cultural differences	23	25.6%	43.4%
	Fear of erotic transference	19	21.1%	35.8%
	Sexual practice differences	7	7.7%	13.2%
	Sexual orientation differences	4	4.4%	7.5%
	Spiritual or religious beliefs	5	5.6%	9.4%

Attitudes

Participants were asked to respond to questions pertaining to the ethics, morality, and necessity of having sexuality related discussions with clients. Grammatical errors in this portion of the survey resulted in the use of double negative statements. These errors may have caused some confusion for respondents, who may have answered opposite to what they would have indicated had these survey questions been grammatically correct. However, responses to these questions seemed consistent with responses to other questions in the survey, indicating that respondents understood the meaning of the questions despite grammatical errors.

The findings partially supported the hypothesis that respondents who had taken a human sexuality class were more likely to have a favorable attitude with regards to the ethics, morality, and necessity of discussions about sexuality (see Table 10). There was a significant difference indicating that participants who had taken human sexuality courses were more likely to view sexuality related discussion with clients as necessary, $t(86) = 2.385$, $p = .019$, two-tailed. Those who had taken classes had a higher mean response ($M = 4.09$) than those who had not ($M = 3.67$). There were no statistically significant findings indicating whether or not human sexuality training was a factor in participants' views about the morality and ethics of having sexuality related discussions with clients. Many of the respondents (80%) reported that it was either rarely or never professionally unethical to have such discussion. Additionally, 90% of respondents indicated that it is either rarely or never immoral to have sexuality related discussions with clients.

Table 10

Attitudes about Sexuality Discussions

Description	Attitude	Frequency	Percent	Valid Percent	Cumulative Percent
Discussions are unethical	All of the time	1	1.1	1.1	1.1
	More often than not	1	1.1	1.1	2.2
$n = 90$	Occasionally	16	17.8	17.8	20.0
	Rarely	50	55.6	55.6	75.6
	Never	22	24.4	24.4	100.0

Description	Attitude	Frequency	Percent	Valid Percent	Cumulative Percent
Discussions are immoral	More often than not	1	1.1	1.1	1.1
$n = 90$	Occasionally	8	8.9	8.9	10.0
	Rarely	45	50.0	50.0	60.0
	Never	36	40.0	40.0	100.0

Description	Attitude	Frequency	Percent	Valid Percent	Cumulative Percent
Discussions are unnecessary	More often than not	2	2.2	2.2	2.2
	Occasionally	30	33.3	33.7	36.0
$n = 89$	Rarely	33	36.7	37.1	73.0
	Never	24	26.7	27.0	100.0

Comfort with Addressing Erotic Transference

Respondents were asked about their knowledge of and comfort with erotic transference. Spearman's Rho correlation tests were run to determine the relationship between the amount of human sexuality classes taken and respondents' ability to detect erotic transference. The findings supported the hypothesis that those who had more human sexuality training were more likely to detect erotic transference than those who had less training. There was a positive but weak significant correlation between the amount of classes taken and amount of detection reported ($rs = .253$, $p = .017$, two-tailed). Similarly, Spearman's Rho correlation tests were run to determine if the amount of human sexuality classes taken had an effect on respondents' reports of having experienced the phenomenon in clinical settings. There was a positive but weak significant correlation between the amount of human sexuality classes taken and reports of erotic transference encounters ($rs = .213$, $p = .045$, two-tailed). This indicates that those having taken more human sexuality training may be better able to detect erotic transference, however, over half of the respondents (55%) reported that they were only occasionally, rarely, or never able to comfortably address erotic transference with clients (see Table 11). This data correlates with respondents' reports that their fears of erotic transference are a barrier to addressing sexuality with their clients. Further, this data correlates with qualitative statements made by respondents indicating that erotic transference is an area in which respondents feel a need for more education.

Table 11

Experience with Erotic Transference Encounters

Description	Occurrences	Frequency	Percent	Valid percent	Cumulative Percent
Detection ability	All of the time	4	4.4	4.4	4.4
n = 90	More often than not	69	76.7	76.7	81.1
	Occasionally	16	17.8	17.8	98.9
	Rarely	1	1.1	1.1	100.0

Description	Occurrences	Frequency	Percent	Valid percent	Cumulative Percent
Encounters	More often than not	7	7.8	7.8	7.8
n = 90	Occasionally	51	56.7	56.7	64.4
	Rarely	28	31.1	31.1	95.6
	Never	4	4.4	4.4	100.0

Description	Occurrences	Frequency	Percent	Valid percent	Cumulative Percent
Ability to address	All of the time	4	4.4	4.5	4.5
n = 89	More often than not	36	40.0	40.4	44.9
	Occasionally	25	27.8	28.1	73.0
	Rarely	18	20.0	20.2	93.3
	Never	6	6.7	6.7	100.0

Most of the respondents (95.5%) stated that they felt that addressing issues of sexuality was different than addressing issues of erotic transference and 43.8% of respondents reported that erotic transference and counter transference was more often than not an important component of the therapeutic process (see Table 12). However, as discussed previously, 34% of respondents stated that their fears of erotic transference would be a barrier to having a discussion about sexuality with their clients. The data indicates that respondents may not feel consistently prepared to address the issues with their clients in a comfortable manner and that human sexuality training may increase the comfort and ability of clinicians to address these issues in clinical practice.

Table 12

Knowledge and Therapeutic Use of Erotic Transference

Description	Scale	Frequency	Percent	Valid Percent	Cumulative Percent
Erotic transference is different than sexuality	All of the time	28	31.1	31.1	31.1
	More often than not	58	64.4	64.4	95.6
$n = 90$	Occasionally	3	3.3	3.3	98.9
	Never	1	1.1	1.1	100.0

Description	Scale	Frequency	Percent	Valid Percent	Cumulative Percent
Erotic transference is important to therapeutic process	All of the time	12	13.3	13.5	13.5
	More often than not	39	43.3	43.8	57.3
	Occasionally	33	36.7	37.1	94.4
$n = 89$	Rarely	5	5.6	5.6	100.0

Qualitative Findings

When asked what Smith SSW classes best prepared clinicians to address sexuality issues with clients, 34.9% of respondents reported that they either didn't take any helpful classes or that they didn't remember having taken any classes that helped them to address issues of sexuality with clients (see Table 13). Only 8.4% of respondents indicated that the comprehensive human sexuality class offered at Smith SSW was most helpful while 34.9% reported that social work practice classes were most helpful to addressing sexuality issues comfortably in clinical practice. This may indicate that it may be beneficial to include more in-depth human sexuality training in clinical practice classes that already exist at Smith SSW.

Table 13

Most Helpful Smith SSW Human Sexuality Classes

n = 83	Class	Response Count	Percent of Responses	Percent of Cases
	None/don't remember	29	26.6%	34.9%
	Practice	29	26.6%	34.9%
	LGBT identities	10	9.1%	12.1%
	Boundaries class	8	7.3%	9.6%
	Gender studies	8	7.3%	9.6%
	Human sexuality	7	6.4%	8.4%
	Integrative seminar	6	5.5%	7.2%
	Theory	4	4.5%	6.0%
	Child development	2	1.8%	2.4%
	Couples & family therapy	2	1.8%	2.4%
	Sociocultural concepts & racial identity	2	1.8%	2.4%
	HIV education	1	0.9%	1.2%

When asked for suggestions pertaining to human sexuality curriculum additions, 18.8% of respondents stated a desire for a class that specifically pertained to having clinical discussions about sexuality, and 23.5% stated a desire for curriculum that specifically pertains to erotic transference (see Table 14). These answers reflect an overall consistent theme that corresponds with statistical data, indicating that respondents feel that human sexuality training would increase their level of comfort with addressing sexuality issues in clinical practice.

Table 14

Desired Human Sexuality Curriculum

n = 85	Theme	Response Count	Percent of Responses	Percent of Cases
	None/unsure	20	22.2%	23.5%
	Integrate or specify class re: erotic transference	20	22.2%	23.5%
	Class specific to sexuality discussions	16	17.8%	18.8%
	Integrate sexuality issues into pre-existing classes	11	12.2%	12.9%
	Trauma and functioning treatment	5	5.6%	5.9%
	Mandate human sexuality training	5	5.6%	5.9%
	Integrate sociocultural sexuality issues	4	4.4%	4.7%
	Provide more access to current classes	4	4.4%	4.7%

When asked what training outside of Smith SSW had been effective in participants'

ability to understand and address sexuality with clients, 28.9% of respondents indicated having

taken no additional outside training (see Table 15). Of those who reported having taken helpful

outside training, the majority (37.4%) stated having taken trainings that addressed specific

components of sexuality such as sexual trauma, HIV, LGBTQ issues, ethics, and couples

therapy; and 22.9% indicated that outside training was necessary for license and degree

requirements or career advancement.

Table 15

Human Sexuality Training Received Outside of Smith SSW

n = 83	Training	Response Count	Percent of Responses	Percent of Cases
	Addressed single aspect of sexuality (e.g. trauma, gender)	31	30.7%	37.4%
	None	24	23.8%	28.9%
	Required for career advancement or license	19	18.8%	22.9%
	One on one discussion with trained clinician	16	15.8%	19.3%
	Self directed study or life experience	10	9.9%	12.0%

CHAPTER V

Discussion

The profession of clinical social work has historically focused on providing treatment for diverse populations. Smith SSW is committed to offering curriculum that fosters competent clinical skills for clinicians to effectively address the concerns of oppressed, disadvantaged and at risk populations. Smith SSW graduates are trained to consider how factors such as race, ethnicity, class, gender, sexual orientation, and disability affect their clients' thoughts, behaviors, and overall well being. However, many respondents of this study indicated that their lack of human sexuality training may be impeding their ability to fully address the entire spectrum of their clients' needs. Sexuality is a fundamental component of an individual's health, self-concept, and quality of life (World Health Organization, 1995). Respondents of this study indicated a desire to better understand human sexuality concepts and suggested that clinical training in this area would increase their comfort and clinical effectiveness. The results of this study are consistent with previous studies in that those who had taken human sexuality courses were more likely to initiate sexuality related discussions with their clients than those who had not. Additionally, those with more human sexuality training were more likely to include human sexuality questions in an initial assessment and were more likely to value the necessity of discussions pertaining to sexuality. Respondents who had received more human sexuality training were more likely to detect erotic transference. These results suggest that human sexuality training better prepares clinical social workers to integrate sexuality into assessment,

comfortably discuss their clients' sexual concerns, and detect and address erotic transference and counter transference.

This chapter expands upon the findings of this study as they relate to the relationship between human sexuality training and the ability of Smith SSW graduate to comfortably address their clients' sexuality related concerns. This chapter outlines some of the current barriers that respondents felt were preventing effective clinical discussions about sexuality related issues.

This chapter also discusses respondents concerns regarding erotic transference and describes respondents' feedback pertaining to specific areas which may be useful for future curriculum development.

Comfort

Previous research indicates that sexual knowledge and comfort is necessary for allied healthcare workers' and mental healthcare workers' competency in addressing and treating clients' sexual concerns (Harris & Hays, 2008; Bidell, 2005; Weerakoon et al., 2008, Pope et al., 1993). The results of this study are consistent with previous studies in that those who had taken human sexuality courses were more likely to initiate sexuality related discussions with their clients than those who had not, and those with more human sexuality training were more likely to include human sexuality questions in an initial assessment. These results suggest that human sexuality training significantly contributes to respondents' comfort with addressing issues pertaining to sexuality with their clients.

Most of the participants in this study reported dealing with sexuality related issues in a therapeutic setting at least occasionally, if not more. While the majority of the sample stated having a clear understanding of his or her own sexuality, it is evident that those who have not received training in human sexuality concepts do not consistently feel comfortable addressing the

sexual issues of their clients, regardless of the comfort with their own sexuality. The general attitude of respondents seem to indicate that having sexuality related discussions with clients is moral, ethical and useful to gaining insight about other aspects of a client's biopsychosocial functioning. However, respondents to this study indicated not feeling educated enough to comfortably address issues related to human sexuality. In fact, a lack of human sexuality training was most often reported by respondents as being a barrier to having sexuality related discussions with clients. With comprehensive human sexuality training, Smith SSW graduates may feel better equipped and more comfortable in addressing sexuality issues that are of concern to their clients and may feel better prepared to address erotic transference, thus potentially increasing the efficacy of the therapeutic relationship. Those who had some form of human sexuality training scored higher in areas related to comfort than those who had none, and there was a weak but significant indication that those who had taken more human sexuality classes felt more comfortable with having sexuality related discussions with their clients . These findings are consistent with previous research (Weerakoon et al., 2008).

Training

Nearly half of those who responded to this study reported never having received human sexuality training. Of those who did report having taken some form of human sexuality training, only 18.4% reported having taken a comprehensive human sexuality class at Smith SSW. Similarly, over half of the respondents reported never having taken CEUs related to human sexuality, which indicates that many Smith SSW graduates are not receiving post-graduate human sexuality training either.

The remainder of participants reported having taken courses that address components of human sexuality and data suggests that some training is better than no training in areas

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concerning comfort and ability of addressing sexuality in clinical practice. However, without a clear understanding of human sexuality to provide a framework for these sexuality sub-topics, clinical social workers may not be prepared to address the full scope of sexuality related issues that their clients may present. Additionally, curriculum focused on limited components of human sexuality may be taught under the assumption that clinicians have a pre-existing understanding about the overall definition of sexuality, thus clinicians may be missing vital information necessary to fully understand the components being addressed.

Erotic Transference

Prior research indicates that there is an absence of core curriculum that addresses sexual feelings in therapeutic relationships (Bridges & Wohlberg, 1999; Pope, Kieth-Spiegel, & Tabachnick, 1986; Book, 1995). Over half of the respondents (55%) in the Pope, Keith-Spiegel, and Tabachnick (1986) study indicated that they had not received any training concerning sexual or erotic transference and 24% indicated that they had received very little training. Similarly, findings in this study indicate that Smith SSW graduates also have concerns that are directly related to their ability to address erotic transference. While almost half of the respondents stated that erotic transference was an important component of the therapeutic relationship, over half of the respondents in this study indicated that they felt unequipped to address erotic transference with clients on a consistent basis.

Previous researchers have discovered that, due to absent or improper training about the subject of erotic transference; many clinicians are unable to differentiate between inappropriate sexual conduct and erotic transference (Book, 1995; Stirzaker, 2000). Results of this study indicate that those with more human sexuality training were better able to detect erotic transference. However, specific training on the topic of erotic transference may better assist

Smith SSW graduates in their ability to address these issues comfortably with clients, as a third respondents indicated that their fears of erotic transference was a barrier to having sexuality related discussions with clients and 23.5% of respondents indicated a desire for training that specifically pertains to erotic transference.

Implications for Smith SSW

Previous researchers have indicated that mental health counseling students consistently reported that their training had not prepared them to work competently with the sexual issues of marginal populations (Bidell, 2005). Similarly, a large portion of respondents in this study (43.4%) indicated racial or cultural differences as a barrier to discussing sexuality issues with clients. This may be a good area of emphasis for future curriculum development, as race and sociocultural influences continue to be important aspects of how sexuality is viewed by individuals.

As previously described, participants of this study indicated an interest in developing a better understanding of erotic transference and felt that training in this area would increase their comfort and effectiveness when addressing these issues with clients. This indicates an area of opportunity for Smith SSW to provide continuing education units for graduates and to consider offering more comprehensive training for future students by either incorporating concepts related to erotic transference into current curriculum or by offering courses that specifically address this topic.

Participants of this study reported a desire to explore their understanding of sexuality issues in environments where they may feel free of judgment. About a fifth of participants indicated that they had gained a better understanding of their client's sexual concerns by exploring these issues either with a supervisor or with their own individual therapists. Previous

researchers indicate a need for resources wherein clinicians can feel free to explore and address issues of sexuality without feeling judged or criticized (Pope et al., 1993).

Interestingly, when asked what Smith SSW classes best prepared clinicians to address sexuality issues with clients, 34.9% of respondents stated that social work practice classes were most helpful. These particular classes allow students to expand their clinical skills and apply various theoretical models to therapeutic interventions. These classes offer hands-on curriculum that focuses on therapeutic relationship skills. The fact that respondents named this class as a desirable platform for human sexuality education may indicate a need for clinicians to explore human sexuality concepts in a hands-on environment that is conducive to open dialogues and comfortable exchanges of non-normative human sexuality perspectives.

Study Limitations

Recruitment for this study called for voluntary participation; therefore data may be reflective of a population that already had a specific interest in the topic. While the study was designed to collect information anonymously, some respondents sent emails which stated their interest in the topic. This may imply that responses to this study may not be reflective of Smith SSW graduates as a whole. Additionally, the population recruited for this study consisted of Smith SSW graduates only and did not include graduates from social work programs offered by other universities. Therefore, responses to this study reflect a limited population of clinical social workers.

While the instrument design of this study was based on pre-existing instruments with high internal consistency, the instrument for this study was developed to include aspects that previous instruments did not include. Some of the survey questions in this study were constructed in such a way that caused answers to have grammatical errors resulting in double-

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negative statements. While responses to these questions indicated that respondents understood the questions despite the grammatical errors, some respondents sent emails noting that these questions could potentially cause confusion for respondents.

Questions included in the instrument were not originally considered with scales in mind. This caused limitations that prohibited the successful development of scales that may have provided a better understanding of the variables involved in the study. Had this researcher been more experienced in the development of scales and statistical analysis, an instrument would have been developed using scales with stronger internal reliability and results may have better answered hypothesis questions.

Conclusion

Clinical social workers are constantly exposed to a diversity of societal and cultural attitudes about sexual expression. These attitudes vary based on age, gender, race, educational, and socioeconomic status (He et al., 2010; Higgins et al., 2010; McGuire & Barber, 2010; Mollborn & Everett, 2010; Stulhofer et al., 2010). It is not uncommon for clinical social workers to address issues related to cultural diversity, non-normative social values and marginal populations. In order to provide culturally competent mental health care, it is necessary for mental health clinicians to develop a clear understanding of sexuality from their client's perspective. Clinicians with no training in human sexuality may act on assumptions and preconceived notions that unintentionally harm their clients.

Previous researchers have examined the relationship between human sexuality training and the level of comfort among marriage and family therapists, psychologists, and allied healthcare workers such as nurses, occupational therapists, and physical therapists. These researchers have concluded that mental health and allied healthcare workers have an increased

comfort and ability to address issues of sexuality after having received human sexuality training. This study reflects similar findings among clinical social workers who have graduated from the Smith SSW program within the past 10 years. Respondents who had received some sort of human sexuality training reported that they initiate sexuality related discussions with clients and viewed such discussions as necessary more often than those with no training. A positive correlation was found between the amount of human sexuality training respondents had received and their inclusion of sexuality related questions in biopsychosocial assessments. Additionally, a positive correlation was found between the amount of human sexuality training received and respondents' reports of detection ability and frequency of experiences with erotic transference encounters in therapeutic relationships. This indicates that the more human sexuality training clinical social workers receive, the more comfortable they are to address their clients' sexuality related issues and the more prepared they are to detect erotic transference.

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Appendix A

Instruments

Demographics

1. I identify my gender as
    a. Male b. Female c. Other (please describe) _____

2. I identify my race as
    a. African American or Black
    b. Asian
    c. Caucasian or White
    d. Hispanic or Latin American
    e. Native American or Alaska Native
    f. Native Hawaiian or Other Pacific Islander

3. My age is
    a. 24 to 29 years
    b. 30 to 35 years
    c. 36 to 39 years
    d. 40 to 45 years
    e. 46 to 50 years
    f. Over 50 years

4. I have a clear understanding of my own sexuality
    a. All of the time
    b. More often than not
    c. Occasionally
    d. Rarely
    e. Never

Education and Training

5. I graduated from Smith SSW in the year: _____

6. During my graduate education at Smith SSW I took a human sexuality class
    a. As an elective
        i. Please list elective classes taken _____
    b. As a component of other required or elective classes
        i. Please list classes _____
    c. Human sexuality was not covered during my education at Smith SSW

7. I have taken undergraduate or graduate level human sexuality courses
    a. Yes
    b. No

8. I have taken continuing education human sexuality courses
    a. Yes
    b. No

9. In total, I have taken
    a. More than 5 human sexuality courses
    b. 3 to 5 human sexuality courses
    c. 1 to 2 human sexuality courses
    d. I have not taken any human sexuality courses

10. Currently, I would feel competent to do a case presentation or consultation about addressing sexuality in a therapeutic setting
    a. Yes
    b. No

Clinical Practices

11. I have practiced as a post-graduate clinician for
    a. More than 10 years
    b. 8 to10 years
    c. 5 to 7 years
    d. 3 to 4 years
    e. 1 to 2 years

12. I work with sexually related issues in a clinical setting
    a. All of the time
    b. More often than not
    c. Occasionally
    d. Rarely
    e. Never

13. I am comfortable discussing sexual issues that arise in my clinical practice with supervisors
    a. All of the time
    b. More often than not
    c. Occasionally
    d. Rarely
    e. Never

14. I am comfortable discussing sexual issues that arise in my clinical practice with colleagues
    a. All of the time
    b. More often than not
    c. Occasionally
    d. Rarely
    e. Never

Attitudes About Sexuality

15. It's professionally unethical to have sexually-related discussions with clients
    a. All of the time
    b. More often than not
    c. Occasionally
    d. Rarely
    e. Never

16. It is morally inappropriate for a therapist to discuss sexuality with her/his clients
    a. All of the time
    b. More often than not
    c. Occasionally
    d. Rarely
    e. Never

17. It is unnecessary for a therapist to discuss sexuality with his/her clients
    a. All of the time
    b. More often than not
    c. Occasionally
    d. Rarely
    e. Never

Clinical Comfort

18. When conducting an assessment, I ask questions about sexuality
    a. All of the time
    b. More often than not
    c. Occasionally
    d. Rarely
    a. Never

19. What are the barriers to discussing sexuality with clients (check all that apply)
    a. Racial or cultural differences between my client and I
    b. Not enough training
    c. Fears of erotic transference (the client may be attracted to me)
    d. My Religious or Spiritual upbringing
    e. Sexual orientations that differ than my own
    f. Sexual practices that are different than my own

20. I initiate sexually-related discussions with my clients
    a. All of the time – it's a part of my standard practice
    b. Only when there might be sexual trauma history or problematic functioning (ex: impotence)
    c. Only if my client brings it up first
    d. Never

21. Having a discussion with my client about her/his sexuality can provide insight about other aspects of her/his biopsychosocial functioning
    a. All of the time
    b. More often than not
    c. Occasionally
    d. Rarely
    a. Never

Experiences with Erotic Transference Phenomena
    For the purposes of this survey, erotic transference is defined as a reenactment of unresolved internal conflict that presents itself within the therapeutic relationship for resolution and produces intense sexual feelings on behalf of the client or the clinician.

22. I have the ability to recognize erotic transference and/or counter transference
    a. All of the time
    b. More often than not
    c. Occasionally
    d. Rarely
    a. Never

23. I have encountered erotic transference and/or counter transference (ex: sexual feelings) in a therapeutic setting
    a. All of the time
    b. More often than not
    c. Occasionally
    d. Rarely
    a. Never

24. I have the ability to address erotic transference and/or counter transference with my client
    a. All of the time
    b. More often than not
    c. Occasionally
    d. Rarely
    a. Never

25. Addressing sexuality with a client is different than addressing erotic transference with a client
    a. All of the time
    b. More often than not
    c. Occasionally
    d. Rarely
    a. Never

26. Erotic transference/counter transference can be an important component of a therapeutic relationship
    a. All of the time
    b. More often than not
    c. Occasionally
    d. Rarely
    a. Never

Qualitative questions:

1) Which Smith SSW classes best prepared you to address sexual issues with your clients (if none, write "none")?

2) What training outside of Smith SSW have you found effective in your ability to understand and address sexuality with your clients (please list dates, names, and facilitators of courses, lectures, or didactic training received – if none, write "none").

What curriculum would you like to have had during your tenure at Smith that would have best prepared you to address sexuality with your clients? (If none, write "none").

Appendix B

HSR Approval Letter

Dear Cari,

This may be the fastest turnaround ever. When the Smith Alums get home and check their email, all will be in order. You have done a fine job on your revisions and you study is approved.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project. This is an interesting study and I hope lots of people participate as it would be very useful information for the School and for the Curriculum Committee.

Sincerely,

Ann Hartman, D.S.W.

Chair, Human Subjects Review Committee

CC: Kate Didden, Research Advisor

Appendix C

Informed Consent

Dear Participant,

My name is Cari Lee Merritt and I am a Smith College School for Social Work student conducting thesis research that examines the relationship between the human sexuality education of Smith SSW graduates and their comfort level in addressing sexuality with clients. The results of the research will be included in my thesis. If you are a Smith College SSW graduate who has completed your education between the years of 2000 and 2009 and are engaged in a clinical practice with adult clients, I invite you to participate in this secure, anonymous, web-based survey. The survey will require between 30 and 45 minutes of your time.

If you consent to participate, you will answer questions about your Smith College graduate education, training received outside of Smith College, and supervisory experiences that have focused specifically on human sexuality. In addition to some demographic questions, you will be asked about your clinical experience and comfort level with addressing sexuality, erotic transference, and sexual identity with your clients.

This is an anonymous survey and no identifying information will be used in the results or data handling. Any identifying information included by respondents will be cleaned to remove any identifying data. Data cleaning and analysis will be conducted by me with the assistance of a Smith College SSW employee who is specifically trained in confidential data handling. The presentation of data will be generalized and presented as a group statistic as opposed to specific individual responses. All data will be removed from my computer and survey account. Data will

be encrypted, password protected, and stored in a locked box for three years as required by Federal regulations. After three years of storage, data will be destroyed. Should I need to access the data after this three year period, the data will continue to be stored in a secure location and destroyed when it is no longer needed.

There are no known risks of participation. At most, this study may provoke uncomfortable emotions or a recollection of challenging clinical situations. Compensation for participation will not be provided. There is no compensation for participation. Benefits of this study may be an increase in your awareness about how you address human sexuality with your clients. Smith College School for Social Work as well as other institutions and individuals may benefit from the results of this study in the future.

Participation in this study is voluntary. Deciding not to participate or choosing to leave the study will not result in any penalty, and it will not harm your relationship with Smith College School for Social Work. Because of the anonymous nature of this study, it will not be possible for you to withdraw from participation once you have completed the survey questions and submitted the survey.

Feel free to call or email me if you have questions, problems, unexpected physical or psychological discomforts, injuries, or suspect unusual occurrences. You may also contact the Chair of the Smith College SSW Human Subjects Review Committee at.

By clicking "yes" below, you are indicating that you agree to participate in the study and have read and understand the information above, you have had an opportunity to ask questions about the study, your participation, and your rights.

Appendix D

Statement of Disqualification

Sorry, you do not qualify to take this survey.

Appendix E

Resource Referrals

Thank you for your valued participation in this survey. Results of this survey will be emailed to the listserve group by August 20, 2011.

Recommended readings on this subject are: "Sexual Feelings in Psychotherapy" by Kenneth S. Pope, Janet L. Sonne, Jean Holroyd (1993). Published by The American Psychological Association.

A wide variety of educational resources in human sexuality are offered by the following professional organizations:

American Association of Sex Educators, Counselors, and Therapists (AASECT) http://aasect.org/conted.asp

The National Sexuality Resource Center http://nsrc.sfsu.edu/