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Linzy Barnett
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ABSTRACT

Clinicians are trained to address a variety of issues regarding their clients' mental health, but how well are professional counselors being trained to explore "alternative" sexual expressions, erotic (counter) transference, gender identities, and the enumerable ways clients can have concerns or issues with aspects of their sexuality? Within this study 15 clinicians were interviewed regarding their experiences within graduate school and the level to which they felt competent and prepared to discuss topics of sex, gender, and sexuality within a clinical context. Many of the participants described utilizing their personal life experiences, self-sought trainings, and individual reading choices as ways to develop adequate education in these topics as all clinicians felt as though their programs did not provide comprehensive education and training in these areas. This study ultimately strives to raise awareness to the gap in professional training clinicians are receiving in the hopes of helping to expand the curricula being offered to graduate level clinicians across disciplines within the professional counseling field.

**WHAT DO CLINICIANS KNOW ABOUT HUMAN SEXUALITY AFTER LEAVING
GRADUATE SCHOOL?**

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

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2014

ACKNOWLEDGEMENTS

First, thank you to all of the amazing participants who donated their time and energy to this project. Second, I am absolutely grateful to all of the wonderful people in my life who have supported me through this intense process of grad school and “Smith Summers.” Third, I could not be more appreciative to my thesis advisor for helping me keep this project maintainable. Lastly, I would like to acknowledge all of the dedicated Smithies who kept me on track, offered twinship, and participated in parallel writing sessions.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS	ii
TABLE OF CONTENTS.....	iii
CHAPTER	
I INTRODUCTION.....	1
II LITERATURE REVIEW.....	3
III METHODOLOGY	16
IV FINDINGS	23
V DISCUSSION.....	34
REFERENCES	42
APPENDICES	
Appendix A: Recruitment Letter.....	46
Appendix B: Informed Consent Form	47
Appendix C: Interview Guide.....	48
Appendix D: HSR Approval Letter.....	49
Appendix E: Correction Sheet.....	50
Appendix F: Amendment Approval Letter	51

CHAPTER I

Introduction

Why are therapists being trained to become culturally competent across race, class, and socioeconomic status, but not regarding sex, gender, and sexuality within the course curriculum? Are we leaving social work school without the knowledge and capabilities to address our clients' needs around human sexuality topics including: masturbation, polyamory, sexual orientation, erotic transference and countertransference, problematic sexual behaviors, bondage and dominance, sadomasochism and masochism, and the various ways people express their sexual attitudes, values, and behaviors? Are we being pushed to look at how our own attitudes and beliefs affect this work? Who do we value as having the right to be sexual? Are we perpetuating heteronormativity in our work? Do sex, gender and sexuality matter?

The purpose of this study is to answer the following question: "What is the level of training and preparations clinicians receive in graduate school regarding topics of sex, gender, and sexuality?" One reason for conducting this study is to examine and potentially improve the current curricula being utilized in graduate level programs educating professional counselors. Another reason is because the literature on this topic does not directly explore the curricula, as much of the literature addresses the correlation between comfort and competency and education. This researcher believes it to be a crucial role of clinicians to be adequately prepared and educated on how to address clients concerns and/or issues around human sexuality, including sex, gender, and sexuality. We are complex beings who have many aspects of ourselves that show up within a therapeutic alliance, and it is our ethical responsibility as clinicians to be able to provide safe, informed, and comprehensive mental health services to our clients.

This study will be conducted by interviewing a sample of fifteen professional counselors across disciplines regarding their graduate level education specifically around the topics of sex, gender, and sexuality. In order to obtain study participants, the researcher plans to utilize a snowball sample through professional networks. The initial contact will include introducing myself, briefly describing the study, and requesting participation. Once consent has been given, the researcher will use the interview guide to collect data.

It is the goal of this empirical investigation to make a contribution to the literature currently available on topics of human sexuality, as well as convey the need for professional counseling programs to further the education their students currently receive around sex, gender, and sexuality in order to provide ethical care to clients. May this work help inform and push clinicians to examine their personal knowledge, ideas, and biases on such topics when working with clients, as it is this researcher's idea that the personal is also the professional.

CHAPTER II

Literature Review

The researcher is going to briefly discuss the various literature available regarding sex, gender, and sexuality within the context of therapy, first within the context of the NASW code of ethics. The work has been divided into several topics including sexual orientation, “alternative” expressions, and gender. Following this the researcher will attempt to discuss the implications of current literature with regard to the intersection of graduate training and human sexuality as well as possible implications for policy and practice.

The NASW Code of Ethics (2008) speaks to the need for comprehensive curricula including all types of human relationships with the following two statements: “Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, mental or physical disability” and “Social workers recognize the central importance of human relationships...Social workers seek to strengthen relationships among people in purposeful effort to promote, restore, maintain, and enhance the wellbeing of individuals, families, social groups, organizations, and communities” (socialworkers.org). These basic social work values indicate that we should be receiving inclusive training that promotes both a critical consciousness and queer consciousness in order to deconstruct concepts of normativity around sex, gender, and sexuality. Critical consciousness in this context can be described by Bransford (2011) as encouraging clinicians to “question how the dominant ideology has shaped their perspectives about their professional

roles...to examine how the taking up of the authority within their professional roles may be perpetuating prevailing authoritarian power differentials” (p. 935).

“Alternative” Sexual Expressions

Issues of invisibility and exclusivity around human sexuality that goes beyond the monogamous, heteronormative standard imposed by society still remains problematic. “Alternative” sexual expressions and identities, such as homosexuality, polyamory, asexuality, and bondage dominance and sadomasochism (BDSM), continue to be marginalized, discriminated against, and targeted by violence. Duncan and Hatzenbuehler (2014) illuminate this by explaining, “Data from the Federal Bureau of Investigation demonstrated that 17.4% of the 88,463 hate crimes between the years of 1995 and 2008 targeted sexual minorities, a rate that was more than 8 times what would be expected when one considers the relatively low percentage of sexual minorities in the general population” (p. 272). This leaves these populations vulnerable, and more likely to experience stress, depression, suicidal ideation, and other forms of mental health issues as a result of the ongoing, complex trauma they experience in relation to their identities. As mental health clinicians who are a part of these societal systems that continue to perpetuate these difficulties, we need to be aware of not only our own assumptions that we bring into the room but of the unique needs and considerations of these populations as we prepare to provide mental health services to individuals.

Sexual Orientation

A recent internet study, including 17,785 subjects, 70% of whom were from the United States and the other 30% came from 48 countries, attempted to look at sexual orientation to investigate whether there truly are only three categories, straight, gay/lesbian, or bisexual, or if sexual orientation can be seen through a fluid-continuum lens greatly influenced by Alfred

Kinsey's work. Congruent with the hypothesis, the study was able to see "only 6.2% of the respondents had a perfect straight score, and only 1.2% of the respondents had a perfect gay score, leaving 92.6% of the sample with past or present attractions to both same sex and opposite sex individuals" (Epstein, 2012, p. 1378). The researchers go on to discuss the implications of these results, and how this has significant meaning for sexuality. Epstein (2012) says, "If this confirmation of Kinsey's findings is valid, it could be argued that researchers have a special obligation to view sexual orientation from the continuum perspective" (p. 1378). So while Epstein is speaking specifically to the utility of these data among sexuality researchers, the current researcher believes this study has serious implications for the way we conceptualize, enact, and address sexual orientation not only within our personal lives, but within the therapeutic alliance. This set of findings has the potential to completely deconstruct the binary of gay and straight as well as the myths of the uncommitted bisexual.

Godfrey, Haddock, Fisher, and Lund (2006) further this idea by stating, "Unfortunately, the majority of therapists are not prepared to work with LGB clients, and many therapists have not worked on their personal homophobia, heterosexism, or other LGB related issues. Given this, many LGB clients do not receive the quality of care they deserve" (p.499). It seems as though we truly need to break from this heteronormative model of being, and open our analysis to our own personal beliefs, attitudes, and behaviors in order to move to "an emphasis on sexual pleasure [in order to] feel free to construct who you want to be and to become a positive force for sexual health and positive sexual experiences...with boundless sexual possibilities" (Weiss, 2012, p. 370-371).

Monogamy and Polyamory

Willoughby (2012) claims, “Premarital young adults have substantially increased their sexual activity during the last 50 years...Today, close to 80% of young adults [have] engaged in sexual intercourse by the time they graduate college...these experiences may change or reinforce existing perceptions about intimacy and relationships,” which makes this researcher specifically think about committed relationships, polyamory, sexual behaviors, attitudes, and beliefs (p. 101). While this is only speaking to the sexual habits of the majority of premarital young adults, this researcher feels as though it speaks to the importance of personal behaviors within sexuality and how they can influence our beliefs, values, and attitudes on a larger context. Southern and Cade (2011) reflect on data showing “50% of couples and 50% of individuals experience sexual problems during their lifespan. Recent research has confirmed that sexual disorders are common, even normative in the United States. Data from a large-scale sample of U.S. adults, aged 18-59 reported prevalence rates of sexual dysfunction in the past 12 months: 43% for women and 31% for men” (p. 246). Therefore it is important we, as clinicians, think about the varying ways to make relationships work.

Barker (2011) suggests, “Our current therapeutic approach to dealing with monogamy is passive: we don’t really address it, and we probably also often assume that the rules we take for granted are the ones that our clients share” (p. 285). Monogamy is often assumed to be the standard for relationships, and clinicians need to be thinking about how this affects not only what we project onto clients but what they project on to us. Barker (2011) goes on to explain, “When working with clients in openly non-monogamous relationships it is important to have some knowledge of these (rather than requiring that the client provides you with an education during the time that they are paying for!). In addition to not assuming that such relationships are necessarily problematic or

pathological (which they are not), it is equally important not to assume that they are perfect solutions to everything!...For all relationships therapy needs to provide an affirmative space for people to explore their motivations, experiences and understandings” (p. 286).

Bondage, Dominance, and Sadomasochism (BDSM)

First, it is important to note that “Up to 14% of American males and 11% of American females have engaged in some form of sadomasochistic (BDSM or SM) sexual behavior...Other estimates indicate that up to 50% of the general population has experienced sexual arousal in response to being bitten while 5% of the population has experienced sexual pleasure in inflicting or receiving pain” (Kolmes, Stock, and Moser, 2006, p. 302). We are talking about a much larger population than many imagine, as this marginalized identity is stigmatized and often shaming for some.

Throughout history people who participate in BDSM have been labeled as problematic, damaged, and dangerous by society, medicine, and caring professions. Often times it is assumed people who participate in such behavior have a history of abuse which has resulted in their sexually deviant behavior, but as Richters, de Visser, Rissel, Grulich, and Smith (2008) indicate, “People who had engaged in BDSM in the past year were not more likely to have been sexually coerced ever or before age 16 years...[additionally] Engagement in BDSM was not associated with higher levels of psychological distress (i.e. feeling sad, nervous, hopeless, etc)” (p. 1665-1666). In fact, after conducting telephone interviews with 10,173 men and 9,134 women the found BDSM to be a subculture whose participants do not exhibit pathological symptoms of abuse or difficulty with “typical” sex. This is important to consider when we look at how clinicians conceptualize and interpret clients who practice BDSM activities.

Kolmes, Stock, and Moser (2006) explain, “Until BDSM practices and lifestyles are included routinely as part of the human sexuality component of training for all practitioners, and until the mental health profession begins to recognize BDSM individuals as a subculture requiring special knowledge, skills, and sensitivity, there remains the risk that therapists may be providing services to BDSM individuals without ever having received appropriate training, or supervision” (p. 306).

Gender

Weiss (2012) who cites Rutter and Schwartz as they state, “Gender difference is so central to ideas about ‘normal’ sexuality that gender nonconformity fuels an exaggerated fear and condemnation of sexual expression outside of a heterosexual model” (p. 369). The information we are spreading regarding sex education in schools, how we promote teen sexuality, pornography, and various laws demonstrate this. We can see this in violence, often sexual violence, incurred by gender-variant and queer individuals.

Martinez, Barsky, & Singleton (2011) indicate “sex-role and gender role beliefs predict antigay attitudes and sexual prejudice...some people react negatively toward individuals who transgress sex and gender norms because they feel a need to maintain rigid distinctions between what they believe are feminine and masculine traits.” They then conclude that many social workers are able to serve clients who present in more traditional ways; “however, the same social workers may have more trouble respecting and working with clients who do not fit such expectations” (p. 308).

Cultural Influences

Cultural influences are at play around issues of sex, gender, and sexuality; therefore clinicians need to be able to address these concerns in a thoughtful and sensitive way. Lavee (1991) reminds us, “Clinical observations show that culture has a strong impact on sexual scripts, beliefs, and behavior. Furthermore, cultural ideology impacts not only one’s sexual practices, but also what is considered normal and dysfunctional and what sort of treatment might be acceptable” (p. 205). This notion seems particularly relevant as therapists will be involved in treatment or referrals of sexual concerns, and perhaps education on the overarching topic of human sexuality will help facilitate sensitive and informed decisions for their clients.

Clinical Views on Relevancy

It is interesting to think about how psychotherapy first began with Freud’s focus on aggressive and libidinal drives, and how they influence our behaviors. Berry (2013) claims Freud oriented sexual sciences “towards a classic psychoanalytic view of sexual behavior, and towards psychogenic explanations of the sexual dysfunctions” (p.59). Freud’s work most often attributed sexual dysfunction to unresolved Oedipal conflicts and the virgin-whore dichotomy, but none the less, this reflects how sexual concerns were being addressed by clinicians as they were seen as a part of psychoanalysis.

Role of Clinician

A study conducted in Boston, Massachusetts from 2006-2008 examined the potential role clinicians can play in improving safe sex practices among clients who have mental illness across race/ethnicity. D’Amore, Cheng, Allensworth-Davies, Samet, and Saitz (2012) state found “Clinicians can play a pivotal role in educating patients about safe sex and helping to increase their knowledge and use of contraception...clinicians have an opportunity to counsel populations at risk

of negative sexual health outcomes, with the potential of affecting patient behavior” (p.2). This implies clinicians can possibly reduce risky sexual behaviors, unintended pregnancies, sexually transmitted infections, and as a result reduce the psychological costs associated with these challenges. Within the study, including 275 individuals, 58% reported moderately severe to severe depression, 40% reported manic episodes, and 16% had at least three psychotic symptoms. D’Amore et al. (2012) explain, “71% (195/275) of the sample reported having a doctor ever talk to them about safe sex. These 195 subjects comprised the sample for the analysis of ever practiced safer sex because of your doctor’s advice” (p.4). This leads the current researcher to believe clinicians should be receiving training on topics of sex in order to more holistically serve our clients, and per the studies below, the more training an individual receives, the more comfortable they feel bringing such topics into therapy. Yerushalmi (2013) states, “Human sexuality is an inseparable part of the yearning for intimacy, merging, and touch, both for people in general and for those with severe mental disorder” (p.62).

Training and Comfort Level

Now, in a society where there seems to be a false sense of sexual liberation, therapists are avoiding the topic. Shaley and Yerushalmi (2009) conducted in-depth interviews with 10 clinical psychologists and psychiatrists who all “seemed to some degree unenthusiastic to develop and engage in a discussion on sexual themes with their patients...none of them believed them to be central to the course and evolution of their therapy” (p.350). While this research included only 10 people from the professional population, I would argue it is a representation of how we have steered ourselves away from the topic of sex and human sexuality as a therapeutic profession because if we are not talking about it in classrooms, why would we assume we are talking about it in the clinical room? The writers go on to examine the causes for this in four major themes

involving the therapists' ideas of how relevant sexuality is to the cause of the behaviors, how exploratory are the orientation and interventions of therapy, the likeliness of therapists to distinguish and separate sexuality and intimacy, and the paradox between the supposed tolerance of sexuality of our current society and the distance and the lack of comfort therapists felt in delving into sexual themes. Along with this, Binik and Meana (2009) exclaim, "In today's psychotherapy world, it is inconceivable that the average therapist trainee would not get some exposure and instruction in the treatment of anxiety disorders or depression: Why is this not the case with sexual dysfunction? Sexual functioning has rated very high in every quality of life study that has measured it and there is 3000 years' worth of literature and art suggesting that it is a crucial aspect of human life" (p. 1024).

Cari Lee Merritt (2011) investigated the relationship between human sexuality training and therapists' comfort level in addressing issues of sexuality with clients. Ninety participants who graduated from Smith School for Social Work from 2000-2009, were found to reflect a positive correlation between adequacy of training about sexuality and comfort with this topic in sessions. The more training therapists had, the more comfortable they were with bringing up the topic within the clinical setting.

Furthering support of a comprehensive curriculum, Harris and Hayes (2008) surveyed 175 marriage and family clinicians to reflect on the effect of sexuality training, education, and knowledge on comfort levels regarding sexuality-related discussions in therapy; they found "As sexuality education and supervision experience increase, therapist-initiated sexuality discussions with their clients also increase. Both sexuality education and supervision could provide mental health professionals with factual knowledge and experiential exercises (i.e., modeling) and dialogue that encourage sexuality discussions with clients" (247). But it is important to

acknowledge the distinction of this education and training as being for marriage and family therapists where sex is considered appropriate and permissible. Life is not compartmentalized, and we as therapist need to be able to tend to our clients' needs in an educational and comprehensive way. This includes being educated and experienced to allow clients to bring all of themselves into therapy, and in this case I am specifically referring to issues or concerns around sex, gender, and sexuality.

Bidell (2005) gathered data from 16 universities using a 7-point Likert scale to address 312 mental health counselors', awareness of their personal attitudes and beliefs in addition to their knowledge and understanding around sexual orientation competency. He found that the higher levels of education the counselors reported, the higher their levels of perceived competency; this placed most of the mental health counseling students feeling ill prepared to appropriately address sexual issues, particularly in marginalized populations such as the LGBT community.

The same increase in comfort is seen with 102 health professional students who used a Likert scale to rate their comfort with a variety of sexuality-related topics before and after attending an online sexuality education course. After the 13 week online course, Weerakoon (2008) discovered, " In general, the level of comfort across a range of sexuality-related situations was raised and the respondents felt more comfortable in asking clients about sexual practices and sexual orientation, as well as answering clients' questions on matters relating to sexuality" (p. 254). This shows how education and training can improve the likelihood that a therapist will examine and acknowledge sexuality-related issues, but it does not address the lack of training around these topics within psychology, psychiatry, counseling, and social work curricula.

Curricula

Some of the earliest articles around teaching human sexuality, circa 1975, reflect this notion of sexuality as separate. Many of them say, “The preferred way of introducing this subject matter is by means of a separate course or section devoted specifically to sexuality” (Valentich & Gripton, 1975, p. 278). It is clear this separation is still being enacted today through the invisibility of sex, gender, and sexuality in curriculums outside of human sexuality courses. Jeyasingham (2008) further speaks to this separation through the exploration of how “systems of knowledge about sexuality in social work operate alongside systems of ignorance—ways of not knowing sexuality or not knowing parts of it—which work to exclude particular ideas, behaviors and groups of people” (p. 138). As social workers we are inherently a part of a larger institutional structure which intrinsically set us up in a patriarchal, heteronormative, white supremacist, capitalist society. Particularly in the case of heteronormativity, certain behaviors are set up by the dominant group as normal and fundamentally right, such as how family can “come to stand for heterosexuality in social work, not because family relationships are intrinsically heterosexual, but through the way in which certain family relationships are imagined as embodying heterosexuality (e.g., parenthood, cohabitating) and given relevance over others (e.g., relationships with siblings, cousins)” (Jeyasingham, 2008, p.142). Additionally, Martinez (2011) points out, “Schools of social work usually do not include lesbian and gay material in the curriculum. Even though presently social workers appear to be becoming more accepting of lesbians and gay men than in the past, the inclusion of lesbian and gay issues is necessary due to the continued rates of homophobia, heterosexism and subtle sexual prejudice among practitioners and students” (p. 559).

Therefore, it is important we be actively engaged in conversations and analysis that will allow us to develop and expand curriculums which prepare us to deconstruct these systems of oppression in order to be able to see our clients as complex and whole while examining our biases

as therapists. There is no reason for sex, gender, and sexuality to be out of that equation. Yerushalmi (2013) reflects on a model of the human experience where “the psychic life is built from representations of physical experiences, and sexuality is rooted in embodied sensory-motor experiences...there is no doubt that eroticism is physical and that the importance of physical arousal in human sexual responses should not be diminished and described merely as social constructs” (p.65).

Martinez, Barsky, & Singleton (2011) further this argument by indicating, “Attitudes are comprised of interactions between beliefs, values, and feelings that predispose people to certain opinions or behaviors” and as a solution they state, “To address sex and gender belief systems as a source of prejudice, educators could provide students with research and information on the range of sex and gender roles that are expressed in mainstream culture as well as across other cultures” (p. 308). We as therapists have been forced to face reality and accept the notion we are not blank slates. We are human beings who bring our own experiences, ideas, beliefs, and attitudes to the therapeutic alliance, and we should explore how those may affect the ways in which we address clients, whether it is around race, class, sex, gender, sexual orientation, and topics involving human sexuality within our educational training in the hopes of not using our paying clients as experimental teaching tools.

Summary

A variety of empirical studies have been conducted mostly between 2005-2008 which show a correlation between education and training and the comfort levels of therapists in confronting sexuality-related topics. The studies generally used convenience samples. Most of the studies utilize a quantitative structure through the Likert scale, but a serious limitation of these studies is

the lack of qualitative data that could have been collected from participants. Overall, they suggest sex, gender, and sexuality are important to the work we do as therapists and should be included in our training. Hilton (1997) explains how one of “the most common failures of therapists is the avoidance of sexual issues altogether. Psychotherapy should be a place where all aspects of an individual’s development, including sexuality, can be discussed” (p. 190). The researcher of this study is curious about the lack of current research being done in this area; the majority of sources came from 2008, five years ago. Perhaps this is because there are empirical studies being conducted as we speak, and they are simply waiting to be peer-reviewed and published. Additionally, much of the research seems to focus on the lesbian and gay community, but I did not find much research on polyamory, BDSM, and other forms of “alternative” expressions of sexuality. Regardless, I do not see how education systems and students of these said systems are integrating these findings. In my opinion, there seems to be enough evidence as to why we need to be including sex, gender, and sexuality within counseling and therapeutic curriculums.

Chapter III

Methodology

Formulation

This empirical study is an exploratory investigation into the training and preparation graduate level clinicians receive specifically regarding topics of sex, gender, and sexuality within therapy. This qualitative study utilized a descriptive research design intended to collect data around the educational and professional experiences of current clinicians regarding their understanding of how well trained and competent they felt leaving graduate school to address such topics with clients in therapy. While there is a body of research, mentioned in the literature review, referencing the positive correlation between education and a clinician's comfort in discussing such topics, there is not a lot of information examining the current education clinicians are receiving in graduate school around human sexuality, including such topics as erotic (counter) transference, alternative sexual expressions, and gender. The present study is designed to investigate this gap in existing literature and suggest ideas and topics for future curricula.

Hypothesis

This study was designed to explore the extent to which clinicians are being educated around topics of sex, gender, and sexuality in graduate school. Literature and personal experience of the researcher indicates a lack of focus and inclusion of human sexuality within graduate school. The hypothesis is that most clinicians will feel undertrained to address the topics of sexuality, sexual differences or gender in their clients' experience or sexuality within the therapeutic dyad.

Research Design

The researcher gathered data through interviews conducted via telephone and Skype with graduate level clinicians across the professional fields of social work, counseling, and psychology. The open-ended interviewing style was guided by seven standardized, open-ended questions (See Appendix C). This method was selected in order to provide the participants with the openness and flexibility to discuss their personal experiences versus giving them multiple-choice, close-ended questions to answer. As stated by Engel and Schutt (2013), “Qualitative research allows the researcher to obtain a richer and more intimate view of the social world than more structured methods” (p. 293). In this study, qualitative interviews were used to explore participants’ views about the adequacy or lack thereof around sexuality education within graduate programs of clinicians. Participants must have at least a master’s level degree in psychology, social work, counseling, or other related field. A positive outcome would be the opportunity to use the results of this study to look at useful ways to implement this material into educational settings nationwide.

For the purposes of this study, biological sex is defined as the physical characteristics that place you on a continuum of female, intersex, or male. Gender identity is defined as a reflection of where individuals’ self-identify lies on the continuum between being non-gendered and either female identified or male identified, while gender expression is defined as behaviors to which are attributed masculinity and femininity. Sexuality is operationalized as “a wide range of sexual phenomena ranging from sexual encounters to sexual fantasies, wishes, and conflicts” (Shalev & Yerushalmi, 2009, p.349).

Eligibility and Exclusion Criteria

Participants were required to hold a minimum of a master’s degree in one of the fields listed above and willing to donate 20-30 minutes of their time, without compensation, in order to

contribute to the knowledge of graduate level training for clinicians. The participants were required to have previous experience in practicing with clients, but there was no minimum. Participants were allowed to include internship and fellowships as experience.

Recruitment Process

In order to recruit participants, the researcher utilized the purposive, snowball method. Clinicians in the researcher's professional and personal network, including friends, family, previous internship site, and current internship site, were contacted via email and Facebook, encouraging them to participate if they currently held a master's level degree in professional counseling. If the clinicians did not meet the eligibility requirement or did not have an interest in contributing to the study they were asked to pass along the recruitment letter (See Appendix A).

The researcher's initial interaction with potential participants was via email as they expressed an interest to participate in the study. From there the researcher sent 15 informed consent documents (See Appendix B) out through the United States Postal Service, with a self-addressed envelope, including postage, to allow the potential participants to send a signed copy back to the researcher without cost. All 15 informed consent documents were signed and returned, to which the researcher scheduled an interview appointment via email for all participants. As a result a total of 15 interviews were completed via Skype, Google Hangout, the telephone, and in person using a recording device.

Methods

All interviews were documented through the use of a recording device made available only to the researcher. In order to ensure confidentiality, the initial recordings were labeled by a random

pseudonym chosen by the researcher, all beginning with the letter P. The recorded data was then fully transcribed by the researcher, in order to accurately capture the data provided by the participants. Once the data was transcribed into a secure word processing program, the researcher was able to analyze the information.

Data Analysis

The researcher used an open coding system to bring about areas of potential significance and common themes within the participant responses that emerged. Initially the researcher created an Excel spreadsheet to organize the respondents answers, divided up by each question. Then the researcher categorized the responses into major themes to which were analyzed. All documents will be stored in a secure location for three years according to federal regulations, and in the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed.

Characteristics of Participants

The complete sample size of 15 was comprised of nine Master's level Social Workers (MSW), two Clinical Psychologists (Ph.D), one Doctor of Psychology (Psy.D), one Master's of Science in Social Psychology (MS), one Master's of Arts with a National Counseling Certificate (MA, NCC), and one master's level Community Counselor (MCC). The participants work with a variety of populations including six who work with severely mentally ill veterans, four who work with people living with HIV/AIDS and substance abuse, one with college students, one with individuals with developmental disabilities, one people with eating disorders, couples, and one in private practice with couples, divorce, and LGBT communities.

Potential Bias

The researcher came to this project with a specific interest in sex therapy, as that is their intended goal following graduate school. Therefore there is an inherent bias as to the importance of human sexuality within curricula. The researcher is passionate about helping individuals explore their sexualities, discover their bodies, and empower themselves to experience all aspects of their lives to which includes sex, gender, and sexuality. In turn the researcher is coming to this project with certain biases that may influence the views of the research.

Summary of Methodology

The present study investigated the ways in which clinicians within the field of professional counseling feel they have or have not been prepared by their graduate programs to address topics of human sexuality within therapy. The qualitative, open method research design allowed the participants the opportunity to provide extensive, thorough answers without the constraints of close-ended questions, multiple choice answers, or predetermined categories to which they had to conscribe to. The participants came from a variety of disciplines, agencies, and levels of experience. While the interviews prevented the clinicians from being anonymous, all possible efforts were taken to ensure confidentiality, such as limited the data availability to the researcher and developing a pseudonym for each participant. Descriptive statistics were utilized when analyzing the demographic data as well as the responses from the participants.

CHAPTER IV

Findings

Overview of the Study

The purpose of this study is to analyze, observe, and make connections from the richness of participants' experiences in various graduate programs and degrees within the field of professional counseling to the amount of training, preparation, and comfort they received around addressing clients' concerns or issues in human sexuality. Participants were asked to describe the ways in which their graduate programs prepared them to address erotic transference and countertransference, people who have alternative sexual expressions, defined as identities outside of the monogamous, hetero norm, the various courses offered in the topics of human sexuality, and what courses they would like to see in graduate programs.

This chapter reviews the demographics of the sample in addition to a summary of the responses provided by the clinicians regarding their training around sex, gender, and sexuality in graduate school. Following this, an analysis resulting from the data collected is presented. The primary findings of this study were that clinicians are not being thoroughly trained in graduate school to address topics of sex, gender, and sexuality.

Sample Demographics

As noted in the methodology chapter, 73% (N=11) of participants identified themselves as female, and 27% (N=4) identified as male. Along with this, the average age of participants was 34.83 years old, with a range of 25-64 years old, and a median of 30 years old. The majority of clinicians in the study identified their race as White/Caucasian (67%, N=10), while 20% (N=3)

identified as Black/African American, 7% (N=1) identified as Asian American, and 7% (N=1) identified as Mexican.

Most of the participants (67%, N=10), identified their sexual orientation as straight/heterosexual, 20% (N=3) as lesbian, 7% (N=1) as queer and bisexual, and 7% (N=1) as demi-sexual, which is the need for emotional connection as a precursor to sexual attraction. Sixty percent (N=9) of the clinicians held an MSW, while 13% (N=2) held a Ph.D, and the other four varied including: Psy.D, MS in Social Psychology, MA, NCC, and MCC. Forty seven percent (N=7) of these degrees were obtained from colleges in the Northeastern region of the United States, while 40% (N=6) were attained from a Southeastern College, and 13% (N=2) were acquired from Mid-Western colleges.

The participants of the study had varying levels of experience as the years of practice ranged from .4 years to 34 with an average of 6.747 years. Among the clinicians in the study there was a wide array of outpatient settings 40% (N=6) worked with severely mentally ill veterans, 27% (N=4) worked with people living or affected by HIV/AIDS and substance abuse, and the other client bases included eating disorders, college students, developmental disabilities, and private practice with a focus on couples and LGBT clients.

How Prepared Do Clinicians Feel?

Of the 15 clinicians interviewed, 100% of them stated they did not feel adequately prepared to address a client's concerns or issues around sex, gender, and/or sexuality. One of the reasons for this is participants felt as though they were lacking the language and questions to ask when thinking about how to approach a client's needs around topics of human sexuality. This is demonstrated in the response, "I wouldn't have even known what to ask...Looking back I really skirted around those issues because I didn't really know what to ask or what to say...and so therefore they were

neglected.” On the other hand some participants felt as though their lack of knowledge would help them remain curious, as one clinician explained “I can only know what I like. What feels good to me. What I’m not willing to do, but I don’t know anything about anybody else’s desires or preferences or things like that...What I feel adequately prepared to do is ask questions.”

In order to combat this, many of the clinicians said they utilized their life experiences and sought out information on their own. One participant explained, “I wouldn’t necessarily say my schooling did that [prepare them to address client’s concerns]. Since my age and life experience and work in the field...that is why...I am able to address it, but if I hadn’t had that I don’t think I would as well. Another participant stated, “I’ve done sort of a fair amount of reading on my own since I graduated to feel more comfortable talking about those issues.” A few clinicians indicated they had attended various conferences and trainings, some offered through their agencies and some they simply found interesting and attended. One of the participants explained supervision had played a large role in helping address these topics with clients, but they did not feel prepared. They described using “supervision as things came up in therapy,” but did not have knowledge ahead of time to know how to better address, describe, or explore topics of sex, gender, and sexuality with clients.

Courses Offered In Graduate School?

Most participants did not feel adequately prepared to address a client’s concerns around sex, gender, and sexuality because 60% (N=9) endorsed taking one class in graduate school pertaining to the topic of human sexuality compared to the 33% (N=5) who reported taking no classes. One participant reported taking two classes. Of these classes, the majority (63%, N=7) were focused on cultural diversity, and 18% (N=2) were dedicated to human sexuality with the other 18% (N=2) being courses on LGBT issues. Of these classes, half were electives and half

were required. The content of these classes was described as basic and general overviews, often with one class period being dedicated to these issues, for example definitions of the acronym LGBTQQI (Lesbian, Gay, Bisexual, Trans, Queer, Questioning, and Intersexed). One participant whose class was cultural diversity stated they had one class period addressing sexual orientation and said, “It was basically like, people are gay. You’re going to have to work with them. This is what they might be like.” Another participant reported taking a human sexuality course that was “Great as far as alerting me to the fact that sex and gender was a part of every client’s life, but in terms of how to use it I don’t feel I was well prepared. Like how to speak about it clinically. I have often felt that when sexuality or gender are primary concerns for a client, I feel pretty constricted in working on this with them.”

How Clients Bring Up Sexual Concerns?

Most participants acknowledged the complexities of clients, and endorsed the idea that a client’s willingness and comfort around bringing up sexual concerns in therapy “varies person to person.” Some “Come in and say it right out whether or not they are doing that sheepishly, overtly...Some people need that sort of encouragement that you’re OK with where they are going, and some people, they need that sort of empty, dense space to fill.”

Other clinicians indicated clients rarely discuss sexual concerns directly and more often refer to subtle references. One participant explained, “Most clients are very hesitant...Clients tend to skirt around sex difficulties, and it comes up in different ways. It comes out in either excessive shopping or doing something else kind of excessively because that’s where needs are getting met.”

Some participants seemed to attribute the varying ways clients bring up sex in therapy to how in touch they are with their sexuality or how open they feel about discussing such topics.

Once clinician referred to her experience with the severely mentally ill population (SMI), and indicated, “Some of them are pretty blocked off from their sexuality. It is like they are kind of not accessing that part of themselves. And then some of them are kind of really, really into their sexuality actually. So it comes up...It often will come up when someone is dating or trying to date someone.” Another clinician who works with people infected and affected by HIV/AIDS described his experiences by saying, “It varies. Some people are just extremely open, but more often than not...there has been a trauma history, sexual trauma history, and so there is a lot of shame and stigma surrounded by the topic of sex, and so it is something that is kind of glazed over [by clients].”

Several of the participants mentioned sexual concerns coming up in therapy around safety. A clinician working with adolescents explained bringing these topics up in reference to “safe sex and taking care of themselves.” Another clinician working with SMI veterans discussed sexual concerns coming up around risk reduction in reference to contraception, STI testing, and talking about riskier sexual practices.

One clinician working with individuals with developmental disabilities referred to sexual concerns coming up a lot for their clients “Just because part of their disability is the social piece, the communication piece, and the relationship piece, and trying to help them navigate the social world safely.”

The majority of participants, 60% (N=9), endorsed the importance of clinicians feeling comfortable and able to bring up sexual concerns in therapy. One reason for this was many clinicians felt clients only bring up sexual concerns after they have been explicitly asked perhaps because they are more guarded or are unsure if they are allowed to talk about such concerns. One clinician discussed this by stating clients include sexual concerns in therapy only “If they’re asked”

while another addressed this by stating, “What I find is that some clients bring it up a lot, and some clients really don’t bring it up, and I would need to illicit it if I thought it was relevant for them to talk about.” Similarly, another clinician noted the importance of creating a safe and comfortable environment for clients to explore these topics by saying, “It needs to be brought up more by the clinician that it is a safe space to talk about it.”

Trained To Address Erotic (Counter) Transference?

A hundred percent (N=15) of participants answered “No”, “None”, or “Minimally” to having been trained or prepared by their graduate program to address erotic (counter) transference as it occurs in the therapeutic dyad. Many explained it was a topic their program did not mention, and for the few who said it was mentioned they described having one class period on the topic stating, “Professors would say this happens. Clients may act out in some way, just be prepared that it could come up.” Similarly, another participant said, “I feel like I’ve been taught to name it and then drop it...I feel like psychodynamic education about erotic transference and how it’s a thing that is likely to happen, but I really feel like what I’ve been trained to do is just be like, ‘Oh, that’s erotic transference’ and then stop talking about it.”

As a result of not feeling trained, some attributed feelings of discomfort around this topic as they did not receive training on how to use a “positive process” in addressing erotic (counter) transference in the therapeutic relationship. For example, one clinician described this by saying, “I feel more uncomfortable talking about erotic transference, or like OK I think that this person might have some kind of feelings towards me in a sexual way...I can see myself avoiding that actually.” The practice of avoidance was mentioned by several participants, and as one explained, “I don’t feel like it came up in grad school, or if it did it was probably more transfer the client. I find I don’t bring it up and neither do they.” This idea is further exemplified by another clinician’s

statement, “I mean my usual tendency, I think just as myself in general, is just to kind of brush it off and sweep it under the rug and pretend like it didn’t happen.”

Thirteen percent (N=2) of the clinicians stated they had not experienced erotic (counter) transference with their clients. One of them understood the reason for this as, “No, I haven’t had any training on that...So I didn’t recognize it.” The other attributed being in a long-term, committed relationship and working with gay men as a monogamous lesbian as the ways in which the work has not been complicated by erotic (counter) transference saying, “I think there is sort of not an option necessarily to entertain that...Because of my attraction to women that hasn’t been a problem...I can’t recall an experience where there has been counter or transference issues...but that might be suppressed.”

In contrast, 87% (N=13) of participants described experiencing erotic (counter) transference within the therapeutic dyad, and 47% (N=7) discussed utilizing supervision to strategize how to handle these situations as they were coming up. One participant indicated not receiving training on how to address erotic (counter) transference in course work, but rather “That was supervision training, like individual supervision...Only talking about it because I was experiencing it.” Another clinician echoed this by saying, “I think that I’ve been prepared pretty minimally for that...We did some reading that was helpful, but I’ve mostly received a little supervision about it kind of as it has come up.” Several of the clinicians discussed how supervision allowed them to explore both their personal feelings and the possible underlying feelings of the clients. Supervision was used to explore ways to “address it, and also normalize it [erotic (counter) transference]” in the room and try to figure out “What is that for you?” in terms of the client’s relational patterns, and to “Look at other arenas where this has happened.”

Is It Relevant?

Eighty percent (N=12) of participants indicated topics of sex, gender, and sexuality are “absolutely” relevant in therapy while 20% (N=3) did not answer the question. This is exemplified in the statement, “It was always relevant to the work that they [clients] were doing.” A number of clinicians saw human sexuality as an integral piece of an individual’s life, and this is summed up by a participant who said, “Sex is a huge part of adult life. I think it would be really short sided to say that it’s not a major part of therapy.” Another clinician echoed this idea with the notion, “I think sexual health is an important part of someone’s overall kind of being...When those issues come up it all sort of cycles back to sort of relationships with other people, feeling comfortable in relationships with other people. I feel like it is sort of the larger work that most of them are doing. How to be seen in the world as a sexual person...I do think sexual preference is a huge part of being a human being for most people...We don’t really spend very much time talking about sort of the intimacy of it or the details of it. And therapy of all places is where you should be able to talk about that.”

What Interventions Have You Been Taught?

While a 100% (N=15) of participants did not recall receiving training or information on a particular intervention to aid in helping clients work through a personal sexual concern or issue, 33% (N=5) referenced the importance of keeping an open mind and using curiosity and exploratory discussions to get at the root of the problem. One clinician explained, “I don’t know if I’ve really been taught any type of intervention, but I’ve just always been supportive, open-minded, and just tried to really hold back any sort of thing that I might be holding stuff against.”

A few of the participants also referenced the need for the clinician to be aware of their biases in this process as it can influence how comfortable the client feels in talking about such topics as well as the ways the concerns are addressed in therapy. One participant described this

by saying, “No interventions per se, but a lot of bumping up against my edges and learning that you just have to keep asking questions.” Similarly, another clinician mentioned the importance of “address[ing] the underlying issues without it becoming countertransference issue.”

Two of the participants directly talked about the importance of utilizing assessments to thoroughly explore the sexual concern or issue. One clinician stated, “I don’t know about interventions...I think I just begin to bring it up, and let them talk about it. And then I can go back into an assessment...How sex was handled as a young child. Was there actually any inappropriate touching or behaviors?” Similarly the other clinician explained, “Not making assumptions and doing a holistic assessment including aspects of sexual health, gender, etc, and alternative practices is important.”

Trained to Work With Alternative Sexual Expressions?

Sixty percent (N=9) of participants reported they received no training in their graduate level programs around how to work with people who hold alternative sexual expressions, defined as anything outside of the monogamous, heteronormative sexual expression, e.g. polyamory, BDSM, asexuality, and queer identities. Most responses can be summed up by with one participant’s statement, “My program did not prepare me at all to deal with that.”

In contrast, 40% of participants felt as though they were marginally trained to address clients who hold alternative sexual expression as they had a few class periods dedicated to topics such as sadomasochism and polyamory, or they had a class where they read a few articles discussing LGBT issues. One clinician explained the LGBT elective she took contained a “fair amount of reading...on you know transgender issues,” and it has helped inform their work with this community. At the same time, the participant did not feel adequately prepared to fully address concerns of people who hold alternative sexual expressions. Similarly, another participant

described feeling “minimally prepared just from the very few topics we discussed in my diversity class.”

In order to educate themselves, many of the participants endorsed seeking out their own training, calling on their personal life experiences, or reflecting on their biases to help them relate to clients who hold alternative sexual expressions. One clinician who self-identifies as a monogamous lesbian explained, “I wouldn’t say there is any teaching that has felt like it prepared me. It is mostly through education through actual real live experiences of the clinicians or asking questions, like going to a pride festival and seeing people of all, well not all but many different ways of relating.” Another clinician who self-identifies as a lesbian spoke to the self-sought out education by saying, “I would say that my training with that has mostly been outside of my formal social work education...Experiences that I’ve had...Just going to workshops and getting to know people who identify as these different kind of categories, and getting to understand who they are, how they operate, and knowing people in my life that kind of have these alternative education. Kind of getting to know people and understand them has been the most informative for me.” A straight identified participant indicated the importance of self-reflection by stating, “In some ways it is mostly about my internal work when I’m talking to them about whatever issues are going on. I try to notice what my own...Very aware of any of my own judgments when they come into the room.”

What Courses or Topics Would You Like to See?

The participants listed a wide range of classes and topics they would like to see included in graduate level training around sex, gender, and sexuality. Some of which included the self-reflection of the clinician, intersectionality of identities, sexual orientation, gender, and LGBT issues. Summed up by one clinician's answer of "Everything and anything" related to human sexuality.

Twenty percent (N=3) of participants felt it was important for the clinician's to use self-reflection to challenge their biases, examine their own identities, and look at possible areas of countertransference. One participant explained, "Being comfortable I guess with yourself, your own sexuality, and with the choices of other people is really important."

Twenty percent (N=3) of clinicians mentioned the importance of intersectionality as one participant described wanting "A required course on looking at intersections of another identity or domain with the intersection of sexual identity because I find that's often where those intersections cross that's where the reluctance is, and that's where the internal conflict is formed." Many of the participants felt there should be more of a focus on how race, religion, and ethnicity influence or affect a person's sexual identity. For example, "I think just a lot more education on sexual preferences and tendencies of minority individuals, like in black and Hispanic communities, and just how their culture kind of addresses the issue and how it may be different from American culture...Just how cultures, religions, ethnicities kind of embrace sexual orientation...Kind of the history of it, and kind of the way they are feeling about it now."

Thirty-three percent (N=5) of participants discussed wanting to see more courses on gender, with a particular focus on not having it conflated with sexuality and Transgender issues. Many of the clinicians described wanting to see more education on the Trans community with a focus on helping therapists be more "comfortable and talking about the transgender experience

and understand how to work with those clients” explicitly around transitioning. One participant would like to see gender dysphoria education covering, “How are we going to address this with them? What are the things you need to think about and ask and consider in moving forward? How can you best help this person move through this?” Another participant broadly explained, “The more we talk about any topic, especially sex and gender issues, the more educated and more helpful we can be.”

A majority of the participants, 47% (N=7), mentioned wanting to see more classes about sexuality and sexual orientation, and 27% (N=4) felt like such classes should be a required part of the curriculum, not just electives offered. One participant stated, “I think it should be mandatory because human sexuality is part of everyday human experience regardless of whether or not you act on it.”

CHAPTER V

Discussion

Introduction

This study addressed clinicians' assessments of the training they received in graduate school regarding topics of human sexuality and how to address them in therapy. Given the researcher's personal experience of not receiving much training on such topics of sex, gender, and sexuality in graduate school, it was this researcher's expectation that most clinicians across the professional field are not adequately being prepared to address erotic (counter) transference, work with clients who hold "alternative" sexual expressions, and a client's difficulties around various aspects of human sexuality. Through these interviews it was discovered none of the participants felt well prepared to help clients address sexual concerns, confront erotic (counter) transference, or work with populations who hold alternative sexual expressions after completing their graduate level training. Many of them chose to seek out further education in these areas, some felt their personal identities and life experiences helped inform them, and all of them stated a desire for more courses in the areas of sex, gender, and sexuality.

Summary of Findings

In exploring the training clinicians are receiving in graduate school around topics of human sexuality, the study indicates professional counselors are leaving their programs with a lack of preparation around such topics. These results were expected by the researcher, as their own experience of graduate school training was similar. Many participants indicated receiving a class around cultural diversity that included one to two class periods surrounding LGBT issues, and most of them indicated the information was around basic definitions and generalizations that did

not particularly address applications for therapy. No participants felt their programs adequately discussed how to address erotic (counter) transference, possible interventions to be utilized with clients experiencing sexual difficulties, and no focus on how to work with clients who hold “alternative” sexual expressions. This implies a need to examine the current curricula being used in graduate programs for professional counselors in order to provide comprehensive, inclusive, and adequate care to all clients regarding all aspects of themselves. If we cannot bring our whole selves into the therapeutic alliance, where can we examine such issues?

Connections to Literature

Many aspects of the literature refer to the level of education clinicians receive to the level of comfort they feel in bringing topics of sex, gender, and sexuality into the therapeutic dyad. One of the results of a lack of education on human sexuality topics is the clinician’s tendency to avoid such topics. This is demonstrated by Hilton (1997) who says, “The most common failures of therapists is the avoidance of sexual issues altogether. Psychotherapy should be a place where all aspects of an individual’s development, including sexuality, can be discussed” (p. 190). This was evident in the findings of this study as many participants referenced an unwillingness or discomfort around bringing these topics up in therapy as they felt ill prepared. As one respondent said, “I wouldn't have even known what to ask...Looking back I really skirted around issues [of human sexuality] and didn't really go into that because I didn't really know what to ask or what to say...and so therefore they were neglected.” Another participant talked about this in a similar way by saying, “I think I am more comfortable with it too now. So I will ask you know, so how’s your sex life? How’s the sex going?” This reflects on the importance of education as a tool to feeling comfortable and competent to address a client’s sexual concerns in therapy.

Another trend in this study was the lack of interventions being taught to clinicians around sexual concerns. As none of the participants were trained on how to directly address sexual

concerns, this is in contrast to Binik and Meana (2009)'s ideas that, "In today's psychotherapy world, it is inconceivable that the average therapist trainee would not get some exposure and instruction in the treatment of anxiety disorders or depression: Why is this not the case with sexual dysfunction? Sexual functioning has rated very high in every quality of life study that has measured it and there is 3000 years' worth of literature and art suggesting that it is a crucial aspect of human life" (p.1024). Clinicians are leaving their graduate level programs without a vast understanding of how to explore and treat sexual concerns. Some of the participants interviewed did feel as though their training helped prepare them to keep an open-minded and use exploratory, talk therapy which could be used when dealing with various aspects of a client's sexuality.

Overall the findings of the study prove much of the literature to be correct, as they show clinicians perceive themselves as more competent, comfortable, and able to provide comprehensive care as their education levels increase. Unfortunately the participants of the study did not receive high levels of education around topics of sex, gender, and sexuality, and therefore often did not feel competent or comfortable with providing services in these areas. One participant indicated, "If someone came to me with sickness or concerns or questions around sexuality I would share what I have learned, but I would also probably refer to someone who might be better suited to them." Another described only having one class period in school around "alternative" sexual expressions and explained, "I learned that it is not wise or ethical for me to try to handle it on my own because it's not something I have any sort of experience in or expertise, and most likely I will come off as judgmental." While this researcher agrees clinicians should not be providing care to clients without an awareness or understanding of the issue at hand, it is important to consider why we parse human sexuality out when thinking about therapy. As Yerushalmi (2013) explains,

“Human sexuality is an inseparable part of the yearning for intimacy, merging, and touch, both for people in general and for those with severe mental disorder” (p. 62).

Benefits of Participation

Benefits to participation in the study included the ability to provide feedback on the current level of training graduate level clinicians are being afforded around the topics of sex, gender, and sexuality. This has the potential to allow participants to influence and improve future graduate program’s curricula. Additionally, the interviews provided a space to discuss the dissatisfaction with their training as well as the knowledge the participants gained through self-sought-out education. Many of the respondents commented on their appreciation for having the opportunity to explore and analyze the information they are already equipped with as well as the areas in which they would like to seek further training.

Strengths and Limitations

Up front the researcher is aware the study is significantly limited by time, money, and logistics. Without the constraints of time and geography the researcher could have expanded the sample to reach out more broadly and nationally, as the participants predominantly came from the east coast. More time would have allowed the researcher to travel, recruit longer, and ask more in depth questions to further develop the data collected, which would have resulted in a richer, more expansive, and stronger study around the training clinicians are receiving on topics of sex, gender, and sexuality.

This study was primarily limited by the size and composition of the participants, as 15 is a small sample size, and an overwhelming majority of participants were white, straight, female social workers. While many helping professions are predominantly comprised of white, middle – upper class women, and in large part the sample is reflective of this as 73% (N=11) of participants

identified as female and 67% (N=10) labeled themselves as White/Caucasian, it should be noted the researcher is a white, middle class woman, and this may be one of the factors attributing to the participants demographics being similar. Therefore the data presented may not be generalizable.

In the future, with more time and resources, the researcher would like to expand the sample size in hopes of recruiting a wider array of clinicians across disciplines, such as social work, psychology, and licensed professional counselors, in order to more accurately compare trainings. Additionally, it would be beneficial to find more diverse participants in the way of race, sexual orientation, and gender as a way of possibly looking at how intersecting identities may or may not influence awareness of such topics as well as the motivations for self-seeking education and training outside of graduate school.

The National Association of Social Workers (NASW) shows the field consists of 79% females and 20% male, and similarly the social workers involved in this study (N=6) reflected 83% (N=5) female and 17% (N=1) male. The social workers who participated in the study also included 67% (N=4) white/Caucasian, 17% (N=1) Asian American, and 17% (N=1) Mexican identified clinicians, which differs from the NASW's data as they reflect 87% of social work professionals as being white while only 2% are Asian American and 1% is Mexican (www.socialworkers.org). This could be a reflection of the small sample size of the study, yet it still raises the question of whether or not this data could be generalizable.

Similarly, since the researcher utilized a snow ball sample, and is currently in a social work program, this left the study susceptible to being overly saturated with social work participants as the researcher's professional network is mostly comprised of social workers. This is demonstrated by the majority of participants, 60% (N=9), holding an MSW, which leaves the study vulnerable to biasing the results in terms of social work graduate programs.

Also, as recruitment was completed through snowball sampling, which initially began with former colleagues and acquaintances of the researcher. Many of the participants were familiar with the researcher through various professional contexts. Therefore this may have influenced the participants' responses and comfort level when participating in the interviews.

While there are many ways the sample could have been improved, it should not be overlooked that the data provided by the participants within this study was informative and concerning. Many clinicians responded to the initial recruitment email, but did not meet the criteria of holding at least a master's level degree in the field of professional counseling. This is indicative of the interest and willingness of clinicians to discuss the importance of sex, gender, and sexuality in the context of therapy. Additionally, the participants who were able to participate provided critical and telling responses of their experiences and feelings around the education, or lack thereof, they received in preparing them to address and explore significant issues clients experience around their sexual identities and behaviors. The purpose of was to investigate current curricula being provided to clinicians, and essentially, the main finding of this study was that modern day therapists do not feel adequately trained and prepared by their programs to help their clients in areas of human sexuality across the counseling profession.

Ethical Considerations

The researcher submitted a proposal of the study to Smith College School for Social Work Human Subjects Review Board (See Appendix D for letter of approval) as a measure used to ensure all federal regulations and guidelines were met with regards to participant safety, confidentiality, and involvement. Each participant was adequately prepared for participation through the informed consent (See Appendix B) they agreed to via their signature covering the potential risks and benefits of their voluntary involvement in the study.

Another ethical consideration is the researcher knew many of the participants in varying capacities. As such, the researcher could have been biased in the ways in which they asked the questions, and the participants could have been biased in providing answers due to the prior relationships. The researcher acknowledged the participants right to request not to answer any questions throughout the interview and encouraged them to speak freely as none of their information would be shared with others, but this did not likely eliminate all potential biases.

Implications for Practice, Policy, and Research

Social workers fulfill many roles within the community including mental health counselors, advocates, and case managers. The code of ethics to which we are held to explicitly states we “Should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, mental or physical disability” (socialworkers.org). Therefore we should be critical of the education to which we are receiving. Asking ourselves if this is adequate, comprehensive, and inclusive of all ways of being in the world, and in this case specifically regarding the human sexuality. Part of our work is to help empower and give voice to those identities, marginalized groups, and/or disenfranchised parts of not only our clients but ourselves, and a large part of this work begins with education. This study shows we need to expand the education being provided around topics of human sexuality in graduate school, and particularly look for ways to be more inclusive regarding people with “alternative” sexual expressions, such as those who identify as asexual, polyamorous, LGBT, queer, or practitioners of BDSM. We owe it to our clients to acknowledge we are not blank slates. Who we are, the experiences we have had, the ideals that we hold, and the training we receive all influence how we sit in the room with clients, and we need to be ensuring our clients the best care

possible by improving our education, examining our countertransference, and embracing the intersubjectivity of the therapeutic dyad.

Therefore, further discussions, lectures, workshops, and course work specifically focused on the many topics encompassed in human sexuality and its complexities may help clinicians better navigate a client's issues or experiences in future practice. For example, in order to become a certified sex therapist, one of the requirements is to attend a Sexual Attitudes Reassessment class (SAR), which allows clinicians to examine the wide array of sexual practices many people engage in and process your assumptions, feelings, and ideas. This intention of this is to help clinicians to become aware of their biases and possible countertransference that may arise in the hopes of being able to provide more conscious, adequate, and comprehensive care. What if such a class was required of social workers, psychologists, and counselors?

Conclusion

The topics of sex, gender, and sexuality within graduate level training of clinicians has not been extensively researched, and of the data that has been collected, most has not directly examined the influence this gap in training has upon the therapeutic alliance. This study aimed to directly investigate the level of preparedness clinicians feel when addressing issues, concerns, and experiences of clients around topics of human sexuality. Within the interviews conducted, it was discovered clinicians do not feel adequately trained to work with clients who hold "alternative" sexual expression, use erotic (counter) transference in the therapeutic dyad, or specifically help clients in exploring their concerns around sex, gender, and sexuality.

Throughout the interviews many clinicians described seeking training and education outside of their graduate level degrees, to which was often influenced by curiosity, life events, or their own identities. Almost all participants indicated they wished they had received more

education around sex, gender, and sexuality, and an overwhelming majority of them further declared a need for more required courses in the area of human sexuality.

A variety of clients will seek therapy with all kinds of providers regarding all types of issues, concerns, and behaviors. It is our responsibility as mental health professionals to be offering conscious, intentional, and appropriate services to all clients, and in order to do so we need to be educated on an array of topics, including sex, gender, and sexuality. The research within this study demonstrates the need to expand graduate level education of professional counselors to be inclusive of all forms of human sexuality, and especially of individuals who express themselves outside of the monogamous, heteronormative standard. People are complex and ever changing, and we need to be updating and improving our education along with the needs of our clients so we can be thoughtful, attuned, and respectful clinicians to those who seek our help.

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APPENDIX A

Recruitment Letter

Dear Colleague,

My name is Linzy Barnett, and I am currently an MSW student at Smith College School for Social Work. I am in the process of conducting research for my thesis, which explores the education and training counseling professionals receive around gender and sexuality within a therapeutic context. The Smith College Human Subjects Review Committee has approved this study, which will be prepared as a thesis and used for possible presentations and publications.

Since you are a counselling professional with at least a master's degree in social work, psychology, and/or mental health counseling, it would be most helpful to know your thoughts about your training approaches to human sexuality in therapeutic work. If you choose to participate in this study, it will involve completing a 20-30 minute interview either in person, through skype or google hangout, or over the phone. You will be asked 7 demographic questions and 7 questions regarding your personal exposure to topics of sex, gender, and sexuality throughout graduate school and how prepared you feel to address these topics therapeutically.

Participation in this study is voluntary. You may refuse to answer any questions during the interview process, and I will keep all data confidential. Unfortunately, I am unable to offer any financial compensation for your time, and I hope a sense of contributing to the knowledge of graduate education might motivate you to participate.

Please feel free to forward this email along to any colleagues you feel may be interested in contributing to the conversation.

Thank you so much for your time and consideration. I hope to see you in an interview as I will be incredibly grateful for any and all contributions to my thesis!

With Gratitude,

Linzy Barnett
XXX-XXX-XXXX

APPENDIX B

Informed Consent

Dear Colleague,

My name is Linzy Barnett, and I am currently an MSW student at Smith College School for Social Work. I am in the process of conducting research for my thesis, which explores the education and training counseling professionals receive around sex, gender, and sexuality within a therapeutic context. The Smith College Human Subjects Review Committee has approved this study, which will be prepared as a thesis and used for possible presentations and publications.

If you chose to participate in this study, it will involve completing a 20-30 minute interview either in person, through Skype or Google Hangout, or over the phone. You will be asked 7 demographic questions and 7 general questions regarding your personal exposure to topics of sex, gender, and sexuality throughout graduate school and how adequately prepared you feel to address these topics therapeutically. In order to participate in this study I am asking that you have completed at least a master's level degree in social work, psychology, and/or mental health counseling.

Your identity and all data collected from the interviews will be kept confidential by assigning each interview a random number. My research advisor will have access to the data collected from the interviews, but as mentioned before, a number will be assigned to your responses in order to provide confidentiality. All data will be stored in a secure location for three years as mandated by federal guidelines. Should data be needed beyond this three year period, it will continue to be kept securely and will be destroyed when no longer needed.

Participation in this study is voluntary. You may refuse to answer any questions during the survey process. I encourage you to keep a copy of this informed consent form for your personal records. Please return a copy to me via the stamped envelope included.

Thank you so much for your time and contribution to my thesis.

Interviewer: Linzy Barnett

Participant:

APPENDIX C

Interview Guide

Demographic Questions:

1. What is your age?
2. What is the race you most identify as?
3. What gender do you identify as?
4. What is your sexual orientation?
5. What is the highest degree in which you have earned and the school from which you earned it?
6. How long have you been practicing?
7. What population do you currently work with?

Interview Questions:

1. How many courses did you have specifically addressing topics involving human sexuality in graduate school? Were they required or elective?
2. As a clinician do you feel that your graduate level training and preparation adequately prepared you for addressing a client's concerns or issues around sex, gender, and sexuality? Why or why not?
3. In your experience, how do clients bring up their personal sexual concerns in therapy? Does it come up often? Do you think it is relevant?
4. In what ways have you been prepared to address erotic transference and counter transference as it comes up in the therapeutic dyad?
5. What interventions have you been taught to address sexual concerns of clients? How do you feel about them?
6. Please describe the ways in which you have been prepared to work with people who hold alternative sexual expressions, such as members of the queer community, asexuality, BDSM (Bondage, Dominance, Sadomasochism), and polyamory.
7. What courses or topics would you like to see addressed in graduate programs regarding topics of sex, gender, and sexuality? Do you think this topic is clinically important?

APPENDIX D

HSR Approval Letter



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

December 13, 2013

Linzy Barnett

Dear Linzy,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

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.

Congratulations and our best wishes on your interesting study.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Claudia Bepko, Research Advisor

APPENDIX E

Amendment Approval Letter



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

February 3, 2014

Linzy Barnett

Dear Linzy,

I have reviewed your amendments and they look fine. These amendments to your study are therefore approved. Thank you and best of luck with your project.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Claudia Bepko, Research Advisor