FAMILY THERAPIST COMFORT WITH AND WILLINGNESS TO DISCUSS CLIENT SEXUALITY

Steven M. Harris
Texas Tech University

Kelli Wenner Hays
Private Practice

Limited empirical information exists on whether or not marriage and family therapists are having sexuality-related discussions with their clients. When helping professionals ignore client sexuality, the potential for unintended negative outcomes increases. The researchers surveyed 175 clinical members of the American Association for Marriage and Family Therapy to assess how their clinical training and education, their perceived sexual knowledge, and their comfort with sexual material influenced their willingness to engage in sexuality-related discussions with their clients. The results indicate that sexuality education and supervision experiences are the cornerstone for a therapist's base level of comfort. It is through sexuality education and supervision that sex knowledge is acquired and comfort levels are increased. Once comfort with sexual discussions increases, then therapists are more likely to engage in sexuality discussions with their clients.

While mental health literature has repeatedly addressed the relevance of therapist sexual knowledge and comfort with sexual matters, few studies (Arnold, 1980; Fluharty, 1995) have done more than assess the efficacy of various human sexuality training models. Likewise, research has shown the importance of therapists' addressing sexual topics with their clients (Bonner & Gendel, 1989; Christensen, Norton, Salisch, & Gull, 1977; Gray, Cummins, Johnson, & Mason, 1989; Haboubi & Lincoln, 2003; Landis, Miller, & Wettstone, 1975). Few studies, however, have explored the variables that might influence whether or not these discussions take place. Furthermore, no researchers have looked at this phenomenon as it pertains specifically to the practices of marriage and family therapists (MFTs). The lack of empirical data on factors that measure and contribute to MFTs' discussing sexuality-related matters with clients is remarkable given the volume of literature that exists on treatment-specific sexual topics (Wincze & Carey, 2001), sexuality training (Drolet & Clark, 1994; Fye, 1980; Stayton, 1998; Weerakoon & Sternberg, 1996), and the likelihood that most therapists will be faced with their clients' sexual problems and concerns at some time (Gray et al., 1989; Landis et al., 1975; Stayton, 1998).

To date, minimal empirical data have been published on how therapists can effectively initiate sexuality-related discussions with clients, despite the fact that researchers have suggested that mental health professionals are not sufficiently trained to work with such concerns. The aim of the present study is to determine to what extent formal sexuality education, perceived sexual knowledge, and comfort with sexual topics influence whether or not family therapists are having sexuality discussions with their clients.

Steven M. Harris, PhD, is Professor of Marriage and Family Therapy in the College of Human Sciences at Texas Tech University; and Kelli Wenner Hays, PhD, is in private practice in Brighton, MI, and specializes in human sexuality.

Address correspondence to Steven M. Harris, PhD, College of Human Sciences, Texas Tech University, PO Box 41210, Lubbock, Texas 79409-1210; E-mail: steve.harris@ttu.edu
REVIEW OF THE LITERATURE

Importance of Sexuality Discussions in Therapy

Hilton (1997) claimed that the most common failure 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 (Gilchrist & Schinke, 1983). How individuals feel about their sexuality will greatly affect their general self-image and confidence. Furthermore, helping families talk about sexuality in an open and trusting environment is increasingly important in a society that is barraged with sexual messages, images, and miscommunication.

Kirkpatrick (1980) surveyed counselors (n = 160) to assess their beliefs about what sexual information would be important to a beginning counselor. The results indicated that respondents assigned high importance to factual knowledge about contraception, abortion, sexually transmitted infections, and puberty, as well as the anatomy and physiology of human reproduction. Items in the survey that measured the ability to help clients adjust to their sexual personality or lifestyle were also rated highly. These specific items included the ability to discuss and assess sexual dysfunctions, same-sex attractions, sex-role equality, and adjustment to a partner’s sexual behaviors. In addition, Kirkpatrick (1980) found that the item with the highest mean response was the ability to discuss a client’s sexuality as easily as other concerns with which a client may present. Although clients expect that mental health professionals will be knowledgeable about sexuality, this is not always the case (Nathan, 1986). This finding, that mental health and other healthcare professionals are often ill prepared to deal with human sexuality, or are uncomfortable dealing with it, has been replicated in other studies (Christensen et al., 1977; Duld & Pokorny, 1999; Haboubi & Lincoln, 2003; Kirkpatrick, 1980; McConnell, 1976; Wiederman, 1999).

The Role of Comfort and Knowledge in Therapist-Initiated Sexuality Discussions

Most health professionals, regardless of discipline, lack sufficient preparation to be considered competent in addressing sexual concerns. Furthermore, the literature underscores the importance of mental health professionals’ need to maintain an accurate knowledge base about human sexuality. What is not clear from the review is the identification of factors that effectively increase therapists’ knowledge about sex and their ability to discuss sexual concerns.

Most therapists have grown up in the same culture as their clients. American culture is often negative about sexuality or is sexually silent (Stayton, 1998). Without proper training, a therapist may be perceived (by the public) as being an “expert,” and yet know less and be more confused and secretive about sex than the client. Even the professional who has adequate sexual knowledge may be unable to be of help to a client because of his or her own anxieties about sexuality (Cross, 1991).

Research has consistently linked sexual knowledge to increased sexual awareness and an ability to work comfortably with clients who have sexual concerns (Anderson, 1986; Bonner & Gendel, 1989; Driscoll, Coble, & Caplan, 1982; Kirkpatrick, 1980; Landis et al., 1975; Yallop & Fitzgerald, 1997). Graham and Smith (1984) designed a study to operationalize the concept of sexuality comfort. High school and college sexuality educators (n = 32) were interviewed with regard to their thoughts about sexuality comfort. The researchers concluded that teachers who were more anxious about communicating sexual information were less effective educators (Graham & Smith, 1984). Thus, while knowledge is a key component to being a sexuality educator, the researchers suggested that comfort with sexuality material is just as an essential requirement.

In a study that examined the sexual comfort levels of occupational therapists, researchers (Yallop & Fitzgerald, 1997) found that most of the subjects expressed feeling uncomfortable and unprepared to deal with sexuality. These researchers concluded that many therapists do
not understand their own sexuality, and so would be uncomfortable initiating conversations about their clients' sexuality. Respondents in this study identified knowledge as the major contributor to comfort with sexuality-related issues and the factor that would most increase their comfort with sexuality. However, it has been postulated that even the professional who has adequate sexual knowledge may be unable to be of help to a client because of his or her own anxiety (Jones, Weerakoon, & Pynor, 2005; Stayton, 1998). Therefore, knowledge alone is considered inadequate preparation for working with clients around sexuality issues.

Therapist Anxiety and Bowen Theory

We believe that Bowen's concepts of anxiety and reactivity are helpful in conceptualizing why a therapist might not engage his or her clients in a discussion of sexuality. According to Bowen family systems theory (Kerr & Bowen, 1988; Schnarch, 1991), it would be difficult for therapists to be helpful to families when emotional responses to the family interfere with one’s awareness of the relationship process. In other words, therapists who become anxious in the presence of anxious clients not only lose sight of the relationship process but also could perpetuate symptoms of the problem within the system.

In most cases, the relieving of anxiety around sexuality issues in therapy is synonymous with avoiding sexuality-related discussions (Schnarch, 1991). Therefore, families that avoid sexuality discussions may need non-anxious therapists to initiate these discussions. Non-anxious therapists model the ability to move past the anxiety that keeps individuals from becoming more fully integrated sexual beings and from having conversations that could facilitate that process (Schnarch, 1991, 1997). This study attempts to discover the relationship between therapists' sexual knowledge and their comfort with sexual material and how these factors influence the likelihood that therapists will engage in sexual discussions with their clients. We believe that clients derive a variety of benefits from MFTs who are sexually educated and comfortable discussing human sexuality. To that end we are interested in discovering just how these variables may influence practice.

Given the existing literature in this area, we propose a study to test the following hypotheses:

- I—MFTs who perceive themselves as having higher levels of sex knowledge will be more likely to initiate sexuality-related discussion with their clients than MFTs with lower perceived levels of sex knowledge.
- II—MFTs with high comfort levels with sexual material will initiate sexual discussions with clients more often than those without.
- III—Therapist perceived sexual knowledge will have a positive influence on therapist sexual comfort.
- IV—Educational and supervisory experiences will have a direct positive influence on MFT perceived sexual knowledge.
- V—Educational and supervisory experiences will have a direct positive influence on sexual comfort.
- VI—Clinical experiences with sexual material will positively influence perceived sexual knowledge.
- VII—Clinical experiences with sexual material will positively influence MFTs' comfort with sexual issues.

METHODS

Sample

Three hundred fifty surveys were mailed to randomly selected clinical members of the American Association for Marriage and Family Therapy (AAMFT). Based on the criteria for clinical membership, we assumed that all respondents would have a degree in MFT or a related
field from a regionally accredited institution of higher education. We also assumed that each of the respondents would have been exposed to family systems theory and sexuality education, and possess a minimum of 100 direct client contact hours and 200 supervision hours. Data were collected over a 2-month period.

Based on the Tailored Design Method (Dillman, 2000), a four-contact sequence consisting of a prenotice letter, cover letter and questionnaire, reminder postcard, and replacement questionnaire was sent to all respondents. Initially, respondents received a letter indicating that they had been randomly selected to participate in the study, based on their affiliation with the AAMFT. The letter informed respondents of the pending arrival of a survey the following week. Those who preferred not to participate were encouraged to contact the researcher so that a survey was not mailed to them. Questionnaires were mailed out the following week. A postcard was sent to all respondents 14 days after the mailing of the survey. The postcard served as both a thank-you for those who had responded and as a reminder for those who had not. The fourth and final planned contact was a replacement questionnaire. This mailing was sent out 2 weeks after the mailing of the reminder postcard. A total of 175 surveys were completed and returned for the present study (response rate 53%).

Table 1 contains demographic information about the sample. Among the listed demographic statistics is a score representing each respondent’s assessment of his or her personal values. Respondents were asked to rate how they considered their own values along a continuum ranging from 1 (traditional/conservative) to 7 (progressive/liberal). The mean for this sample was 4.8 ($SD = 1.4$), which indicates a somewhat more progressive/liberal value system for the overall group.

Of the 175 respondents in the study, 65 were male (mean age = 57 years; $SD = 8.7$) and 110 were female (mean age = 53 years; $SD = 9.9$). The females in the sample indicated having fewer years of clinical experience than the males (16 years compared to 21 years). Both males and females reported seeing a similar number of clients each week (female mean = 20 clients; male mean = 21.5 clients).

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>110</td>
<td>62.9</td>
</tr>
<tr>
<td>Male</td>
<td>65</td>
<td>37.1</td>
</tr>
<tr>
<td>Education level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Master’s degree</td>
<td>131</td>
<td>74.9</td>
</tr>
<tr>
<td>Doctoral degree</td>
<td>40</td>
<td>22.9</td>
</tr>
<tr>
<td>PhD candidate</td>
<td>4</td>
<td>2.3</td>
</tr>
<tr>
<td>Sex therapist certification</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>13</td>
<td>7.4</td>
</tr>
<tr>
<td>No</td>
<td>124</td>
<td>70.9</td>
</tr>
<tr>
<td>Missing</td>
<td>38</td>
<td>21.7</td>
</tr>
<tr>
<td>Mean</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>54.1</td>
<td>9.6</td>
</tr>
<tr>
<td>Personal values</td>
<td>4.8</td>
<td>1.4</td>
</tr>
<tr>
<td>Years in practice</td>
<td>17.9</td>
<td>8.9</td>
</tr>
<tr>
<td>Clients per week</td>
<td>20.5</td>
<td>9.4</td>
</tr>
</tbody>
</table>

Table 1
Demographic Characteristics
T-tests were run on gender, education level, and certification as a sex therapist on the dependent variable of therapists’ sexuality discussions with clients. No significant difference was found for gender or education level with sexuality discussions. A significant difference was found for the 13 respondents who reported being certified as sex therapists: the certified sex therapists were more likely to initiate sexuality discussions with their clients (mean = 5.4; SD = .85) than the respondents in the sample who were not certified sex therapists (mean = 4.6; SD = 1.3), t (137) = -2.15, p < .05.

**Instruments**

The selection of instruments was based on the test’s relationship to the variables under investigation, ease of administration, and soundness of its psychometric properties compared with other instruments. In some cases, questions or scales were developed because an appropriate measure did not exist. Five measures were used to assess individual characteristics of the respondents in the sample.

**Sexuality education and supervision scale.** The Sexuality Education portion of this measure was developed by the researchers to assess the types of sexuality education received during or after graduate school. Seven items ask specific questions about the level of sexual education respondents have received. For example, respondents were asked if they had a graduate course in human sexuality or if they had attended workshops on sexuality. One point was given for each indication of participation in a sexuality education venue. Higher scores on this scale indicate more sexuality education. The Supervision portion of this measure was designed by the researchers to assess the presence or absence of a supervisory experience in which sexuality issues were discussed. Five questions make up this portion of the scale. Higher scores indicate greater experience in discussing sexuality issues with a clinical supervisor.

**Clinical experience scale.** The Clinical Experience scale is a five-item self-report measure, developed to assess the degree of therapist clinical experience with sexuality issues. Respondents complete this scale by indicating which scenarios describe their level of clinical experience with sexual issues and the frequency of such work. Higher scores indicate more clinical experience with sexuality issues.

**The perceived sexual knowledge scale.** The researchers were unable to locate a useful instrument to measure the sexual knowledge of either family therapists specifically or mental health professionals in general. While other instruments exist that measure the sexual knowledge of undergraduate students or beginning medical students (e.g., Sexual Knowledge and Attitudes Scale (SKAT); Lief & Reed, 1972), none of the existing instruments seemed appropriate for the current study. The Perceived Sexual Knowledge Scale requires respondents to rate their level of knowledge on eight distinct sexuality dimensions using a seven-point Likert-type scale (i.e., 1—No Knowledge to 7—Very Knowledgeable). A test of reliability with the current population under investigation revealed a Chronbach’s alpha of .85.

**Sexual comfort scale.** This scale was used to assess the comfort level of the therapists when discussing sexuality-related topics. The measure contains 15 questions and was derived from a study intended to operationalize the concept of “sexuality comfort” (Graham & Smith, 1984). Graham and Smith (1984) conducted a qualitative study based on in-depth interviews with 32 sexuality educators who unanimously agreed that sexual knowledge does not ensure comfort with that knowledge. Chronbach’s alpha for the current study was .86.

**Sexuality discussions with clients scale.** Currently, there is no documented instrument available to measure therapist-initiated sexuality discussions with clients. Thus, the Sexuality Discussion Scale is a nine-item self-report measure designed to assess the presence or absence of sexual discussions with clients. This measure uses a Likert-type response format with scores ranging from 1 (strongly disagree) to 7 (strongly agree) or 1 (never) to 7 (very often). For this scale, higher scores indicate increased willingness of the therapists to initiate sexuality discussions with their clients. Chronbach’s alpha for the current study was .90.
Analyses

The researchers used a path analysis model to evaluate the relationships between the independent variables on the dependent measure of sexuality discussions (see Figure 1). For the purpose of discussion we have labeled the variables by levels. Level One variables include participants' Sexuality Education and Supervision and Clinical Experience with sexual issues. Level Two variables include the therapists' Perceived Sexual Knowledge and their Sexual Comfort. Level Three includes the dependent measure of Sexuality Discussions only. Additionally, the following background variables were examined in post hoc analyses: gender, age, values, education, area of discipline, years in practice, and average number of clients per week. From the post hoc analyses we know that sexuality education and supervision increase therapists' comfort with sexual content and discussions with clients about sexuality issues, regardless of age, gender, the discipline for which the therapist identifies, or years in practice.

Results

The first regression examined the effects of therapist sexuality education and supervision experience as well as clinical experience with sexuality issues on perceived sexual knowledge. Both of these independent variables had a significant direct effect on therapist perceived sexual knowledge. The independent variables explained 27% of the variance in therapists' perceived sexual knowledge (see Figure 2).

With the second multiple regression the researchers investigated the influences of three variables (therapist sexuality education and supervision experience, clinical experience with sexuality issues, and perceived sexual knowledge) on Comfort with sexual matters. Although clinical experience did not have a direct effect on comfort with sexual content, sexuality education and supervision experience and perceived sex knowledge did. These variables explained 48% of the variance in therapist comfort with sexuality matters.

In the final regression, the researchers examined the effects of four variables (therapist sexuality education and supervision experience, clinical experience, therapist perceived sexual

Figure 1. Initial path model.
knowledge, and therapist comfort with sexuality matters) on therapist sexuality discussions with clients. Therapist perceived sexual knowledge did not have a significant direct effect on therapists’ initiating sexual discussions with clients. Therapist clinical experience with sexual issues was close in significance ($p = 0.08$) and therefore worthy of notice. The independent variables overall explained 33% of the variance in therapists’ initiating sexuality discussions with their clients. The final path model highlights the significant variables and is presented in Figure 2.

The findings did not fully support Hypothesis I: MFTs who perceived themselves as having higher levels of sex knowledge will be more likely to initiate sexuality-related discussions with their clients than therapists with lower perceived levels of sex knowledge. Perceived sexual knowledge does not have a significant direct effect on sexual discussions in the path model. There is, however, an indirect influence on sexual discussions by perceived sex knowledge.

Hypothesis II was supported with a statistically significant direct effect between therapist comfort with sexual issues and therapist sexuality discussions with clients. The findings also supported Hypothesis III: Marriage and family therapists’ perceived sex knowledge will have a direct, positive influence on their comfort with sexual issues. There was a strong direct effect between therapist perceived sexual knowledge and therapist comfort with sexual issues. Hypothesis IV, that MFTs’ graduate sexuality education and supervisory experiences will have a direct, positive influence on therapist perceived sexual knowledge, was supported.

Hypothesis V, MFTs with graduate-level sexuality education and supervisory experiences with sexual information will be more comfortable with sexuality-related matters than those without specific graduate course work in human sexuality or supervisory experiences with sexual information, was also supported by the data. As expected, a significant direct effect was found between sexuality education and supervision experience and therapist comfort with sexuality matters.

The sixth hypothesis was also supported. We hypothesized that MFTs’ clinical experience with sexual issues would directly and positively influence therapist perceived sexual knowledge. In the path model, there was a significant direct effect between clinical experience and therapist
perceived sexual knowledge. In other words, therapists' clinical experience with sexual issues positively influenced their perception of their sexual knowledge.

Hypothesis VII was not supported by the data. Therapists' clinical experience with sexual issues did not directly affect their comfort with sexuality matters. However, therapists' clinical experience did have direct and indirect influences on therapists' initiating sexuality discussions with their clients.

A decomposition table with indirect, direct, and total effects of each variable is presented in Table 2. The decomposition table lists the variables that had an effect on the dependent variable, and illustrates the differences in the influences of these variables on therapists' initiating sexuality discussion with their clients. Therapist comfort with sexual content had the greatest direct influence on therapist-initiated sexuality discussions, while sexuality education and supervision experience had the second largest direct influence on therapist-initiated sexual discussions with clients. Therapist sexuality education and supervision experience and therapist comfort with sexual matters had the largest total impact on therapists' initiating sexual discussions with clients, respectively. Therapists' perceived sexual knowledge had the third largest combined influence on sexual discussions, even though it did not have a direct influence. Therefore, therapists' perceived sexual knowledge influences their likelihood of initiating sexuality-related discussions with their clients, but only as it is mediated by a positive influence on comfort, which directly influences sexual discussions.

Regarding the hypotheses posited at the outset of this investigation, only one was not fully supported by the data. Contrary to the hypotheses, no direct influence was found between therapists' perceived sexual knowledge and therapist sexuality-related discussions. Similarly, no direct influence between clinical experience and therapist comfort was found. The supported hypotheses revealed direct influences on sexuality discussions by sexuality education and supervision experiences, clinical experiences, and comfort. Indirect influences on the therapists who had sexual discussions with clients included the therapist's sexuality education and supervision experiences, clinical experience, and perceived sexual knowledge.

**DISCUSSION**

Numerous researchers have argued that sexual knowledge and comfort with sexual content is essential for competency in discussing, assessing, and treating clients' sexual concerns (Cross, 1991; Driscoll et al., 1982; Kirkpatrick, 1980; McConnell, 1976; Stayton, 1998). The findings of the current study suggest that sexuality education and supervision experience addressing sexuality issues are the best predictors of therapists' initiating sexuality-related discussions with their clients. 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.

<p>| Table 2 |
| Decomposition Table |</p>
<table>
<thead>
<tr>
<th>Variable</th>
<th>Indirect effects</th>
<th>Direct effects</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>SupEd</td>
<td>0.17</td>
<td>0.20</td>
<td>0.37</td>
</tr>
<tr>
<td>Clinical</td>
<td>0.05</td>
<td>0.14</td>
<td>0.19</td>
</tr>
<tr>
<td>Perceived</td>
<td>0.20</td>
<td></td>
<td>0.20</td>
</tr>
<tr>
<td>Comfort</td>
<td></td>
<td>0.31</td>
<td>0.31</td>
</tr>
</tbody>
</table>
Sexuality education and supervision experience had an indirect effect on the dependent variable through both perceived sexual knowledge and comfort with sexual matters. Therefore, as the sexuality education and supervision experience of therapists increase they are more likely to perceive themselves as knowledgeable about sex and their level of comfort with sexual matters increases. Again, it is through sexuality education and supervision experiences that most therapists are exposed to factual sexuality knowledge and provided with opportunities to explore and challenge their anxieties around sexuality. These findings support the work of Driscoll et al. (1982), who studied the sex knowledge of family physicians and found that formal sexuality education was considered an important contributor to increase sex knowledge, comfort levels with sexual content, and willingness to address sexual issues. It seems that for this sample, the same holds true for supervision experiences addressing sexuality issues.

The finding that therapist comfort with sexual content was the second strongest influence on therapists’ initiating sexuality-related discussions with their clients coincides with the results of previous research on the developmental stages of therapists as they gain comfort with sexuality matters (Anderson, 1986; Nathan, 1986). While both Anderson and Nathan discuss the influence of increased sexual knowledge on comfort with sexual content, they also recognize increased sexuality-related discussions with clients as a developmental benchmark indicating increased comfort with sexual content. As therapists gain comfort with sexuality-related matters, they are more likely to initiate therapeutic discussions focusing on sexuality-related issues. This finding may support a Bowen family systems theory interpretation of the results for the current study: as anxiety decreases, more flexibility in dialogue or more choices for sexuality conversations are possible (Kerr & Bowen, 1988; Schnarch, 1991).

A similar explanation supports the indirect effect that perceived sexual knowledge had on sexuality discussions, as mediated by therapists’ comfort with sexual matters. Previous research has consistently linked sexual knowledge to increased comfort with sexual content (Anderson, 1986; Nathan, 1986). The results of the present study support a strong direct influence of perceived sex knowledge on therapists’ comfort. Therefore, for these therapists these data suggest that as their perception of their sexual knowledge increases they feel more competent and self-confident in the area. The positive influences of increasing their sexual knowledge expands their comfort level with sexual issues, which, in turn, creates space in sessions for addressing sexual issues with their clients.

Clinical experiences with sexual issues had an indirect influence on sexual discussions through perceived sexual knowledge. Therefore, as therapists gain clinical experience with sexual issues, the perception of their sexual knowledge increases. Surprisingly, clinical experience with sexual issues does not directly influence therapists’ comfort with sexual content. For this sample, it seems as though as therapists work more regularly with clients on sexuality issues, it does not directly influence their comfort with sexual content. This finding may be explained in that participants were asked about their level of clinical experience with sexual issues, but were not asked about the process or outcome of those sessions. It cannot be assumed that all clinical experiences with sexuality issues are growing or learning experiences for the therapist. Thus, it could be that not all clinical experiences accounted for by this sample were positive experiences. If some therapists initiated sexuality discussions reluctantly or begrudgingly, for example, it may not have been a situation that increased their comfort with sexual content.

Given that the current study did not investigate the role of other factors that would logically influence one’s comfort with and willingness to engage in sexuality discussions (i.e., culture, family of origin, religion, etc.) of the variables under investigation, sexuality education and supervision experiences seem to have the most influence on the therapists’ base level of comfort. It is through sexuality education and supervision that sex knowledge is acquired and comfort levels are increased. On the other hand, clinical experiences with sexuality issues may simply reinforce therapists’ base status of comfort. If therapists have a low base level of comfort with sexuality issues, their comfort level does not increase as a result of more clinical.
experience with clients. Consequently, therapists with high comfort levels with sexuality issues do not increase their comfort levels solely through clinical interactions with clients. It is through sexuality education and clinical supervision that comfort levels are increased.

It is of interest to note that perceived sexual knowledge did not directly influence sexuality discussions with clients. This finding, at first glance, seems to contradict what many hold as a Bowen family systems concept that intellectual adeptness (or achieving greater degrees of intellectual differentiation) automatically leads to less anxiety. However, within the framework of differentiation, it is not simply increasing intellectual functioning that contributes to a reduction of anxiety. It is the corresponding ability to “sit with the anxiety” and making a decision to do so that would lead to a greater willingness to initiate sexual discussions with clients. Without the mediating variable of comfort, it seems that objectivity and intellectual reasoning do not necessarily create more flexibility in dialogue. These findings indicate that a perception of possessing sexual knowledge is not enough for therapists to initiate sexual discussions with their clients. Cross (1991) reiterated these findings by suggesting that a professional with basic sex knowledge may be unable to be of help to a client because of his or her own discomfort (or anxieties) about sexuality. Bowen theorists consistently highlight the importance of therapists being a non-anxious presence during anxious times in session. When therapists’ anxiety is increased in session, sexuality discussions and other uncomfortable topics may be avoided.

Directions for Future Research

It would be of particular interest to further investigate the sexuality education curriculum of accredited marriage and family therapy programs. A few questions are raised in regard to this area: (a) How is sexuality education taught at each program? (b) What are the outcome differences between programs that incorporate an entire course devoted to sexuality education and programs that “infuse” sexuality education throughout other courses in the curriculum? (c) Which sexuality education methods are the most effective for influencing therapists’ perceived sexual knowledge, their comfort with sexual content, and their initiating sexuality issues with their clients? (d) How are supervisors addressing sexuality issues with therapists? (e) What supervision methodologies are the most effective for influencing therapists’ perceived sexual knowledge, therapists’ comfort with sexual content, and therapists’ initiating sexuality discussions with their clients? (f) What is unique about the sexuality education and supervision experience that has such a strong positive influence on therapists’ initiating sexuality discussions with clients?

Presently, there have been no studies conducted investigating the influence of clinical supervision on therapists’ initiating sexuality-related discussions. With supervision being the second highest predictor of sexuality discussions in this study, it seems imperative that more research be conducted in this area. In general, it seems that sexuality research in the MFT field would benefit from a better overall understanding of the impact of supervision on therapists’ development in this area.

The introduction of therapists’ perceived sex knowledge to this study has important implications for future research. Measuring therapists’ sex knowledge as they perceive it proved to be an influential factor on comfort with sexual content and initiating sexuality discussions. These findings may signify the importance of therapists feeling competent, regardless of their actual competency level. Therapists would benefit by understanding factors that influence their perceptions about their sex knowledge, and strategies for increasing their feelings of competency. With a more accurate measure of therapists’ basic sex knowledge, it may also be of interest to study the relationship between perceived sex knowledge and actual sex knowledge.

Clinical Implications for Marriage and Family Therapists

A review of the literature reveals that studying sexuality discussions with clients has primarily focused on physicians, occupational therapists, and sexuality educators. Presently, mental
health professionals are finding it necessary and desirable to address various aspects of clients' sexuality. The results of this study indicate that having a high level of comfort with sexual content is a precursor for therapists' initiating sexuality-related discussions with their clients. For clinicians, increasing personal comfort levels with sexual content seems to be more important than perceiving themselves as knowledgeable in the area. Therefore, incorporating venues that facilitate comfort with sexual content seems crucial for graduate and therapist training programs. Based on the findings of this study, comfort with sexual content seems to increase only when therapists perceive themselves as knowledgeable about sex and when they receive sexuality education and supervision experiences that specifically address sexuality issues.

REFERENCES