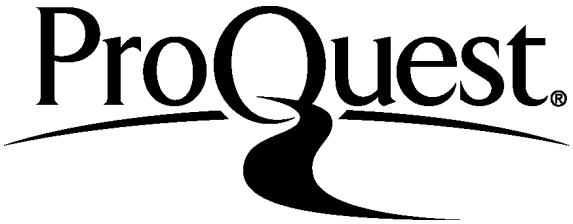
Preparedness of Doctoral Clinical Psychology Program Faculty to Integrate Topics of Human Sexuality into Academic Training

Eliana Swislow

A Dissertation Submitted to the Faculty of
The Chicago School of Professional Psychology
In Partial Fulfillment of the Requirements
For the Degree of Doctor of Psychology

May 27, 2015



Preparedness of Doctoral Clinical Psychology Program Faculty to Integrate Topics of Human Sexuality into Academic Training

A Dissertation Submitted to the Faculty of
The Chicago School of Professional Psychology
In Partial Fulfillment of the Requirements
For the Degree of Doctor of Philosophy in Psychology

Eliana Swislow

2015

Approved By:

Braden Berkey, PsyD, Chairperson
Associate Professor, The Chicago School of Professional Psychology

Michael Gaubatz, PhD, Member
Associate Professor, The Chicago School of Professional Psychology

Robert Foltz, PsyD, Member
Associate Professor, The Chicago School of Professional Psychology

Permission to Reproduce Copyrighted Material

I am grateful to Sandra Byers, Ph.D., for permission to reproduce her protocol, *The Sexual Knowledge Questionnaire* (Copyright 2009; Miller, S. A., & Byers, E. S.)

See letter of permission in Appendix A.

Acknowledgements

I would like to extend my sincerest gratitude to Dr. Braden Berkey, Dr. Robert Foltz, and Dr. Michael Gaubatz for their guidance, support, and encouragement throughout this dissertation process. Thank you for sharing my enthusiasm for the relevance of this topic. I would also like to thank Dr. Philip Adu from NCADE for his support and guidance with the methodology portion of this dissertation. Also, thank you to Leslie Crampton for her support and contributions to this project. Finally, I would like to thank my family and friends for their love and support.

Abstract

Sexuality is a fundamental aspect of the human experience. Despite the intersection between psychological and sexual wellbeing, the majority of doctoral clinical psychology programs do not require, nor offer, courses in human sexuality. Whereas past research has widely focused on graduate student competency, little research has surveyed faculty competency in topics of human sexuality. This study measured the extent to which educators of graduate students are knowledgeable in topics of sexuality, and how comfortable they feel integrating sexual topics into their courses. This study surveyed 52 licensed clinical psychologists who teach in accredited doctoral programs nationwide. Participants were surveyed utilizing a previously developed competency questionnaire to measure knowledge, and a newly created measure to examine levels of comfort discussing sexuality with students. Participants demonstrated greater knowledge of sexual dysfunction than of healthy sexual development. Additionally, participants reported higher levels of comfort when asked to discuss sexuality in general, but reported relatively lower levels of comfort when asked to discuss certain specific sexually related topics with students.

Table of Contents

List of Tables

List of Figures

Chapter 1: Introduction

Sexuality is a fundamental aspect of being human (Reissing & Di Giulio, 2010; Wiederman & Sansone, 1999; World Health Organization, 2006). The overarching term "sexuality" encompasses several categories including, "gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction" (World Health Organization, 2006, p. 10). For the purpose of this study, the focus will be primarily fall on sexual practices, sexual dysfunction, and healthy sexual development. Sexual functioning is an essential feature of emotional and physical health, as tribulations with sexuality can result from, or contribute to, deficits in emotional, physical, or psychological well-being (Reissing & Di Giulio, 2010; Risen, 1995; Wiederman & Sansone, 1999). While sexual health concerns can present as primary problems, they can also be secondary to physical or mental health concerns (Byers & Miller, 2008; Reissing & Di Giulio, 2010). For example, difficulties with sexuality can be associated with a variety of physical and psychological conditions such as depressive and anxiety disorders, substance related disorders, interpersonal conflict, psychotropic medication usage, physical disability, and so on (Gill & Hough, 2007; Reissing & Di Giulio, 2010; Risen, 1995). In light of the intersection between sexual wellbeing and psychological wellbeing, it is likely that a practicing clinical psychologist will encounter topics of human sexuality in some capacity in their practice (Reissing & Di Giulio, 2010).

Despite the intersection between psychological and sexual wellbeing, a number of recent studies suggest clinical psychologists lack key competencies in topics of human sexuality (Hanzlik & Gaubatz, 2012; Kleinpatz, 2003; Miller & Byers, 2009; Reissing & Di Giulio, 2010). A review of American Psychological Association (APA) accredited doctoral programs in clinical psychology reveals that these programs do not routinely address the topic of human sexuality in

their curriculums. Existing research suggests that formal training in this topic is correlated with increased clinical competency (Anderson, 1986; Byers & Miller, 2008; Dixon-Woods, et al, 2002; Gill & Hough, 2007; Hanzlik & Gaubatz, 2012; Harris & Hays, 2008; Hays, 2002). As sexuality is a feature of all populations that clinical psychologists might encounter in their work, the absence of didactic and clinical training at the doctoral level raises concern (Risen, 1995; Reissing & Di Giulio, 2010; Wiederman & Sansone, 1999). This is because without formal training a psychologist might only be comparably knowledgeable to, and similarly as anxious as, their clients with regard to this topic (Harris & Hayes, 2008; Stayton, 1998).

This study examined the systemic influences that may contribute to why clinical psychologists lack key competencies in topics of human sexuality. Systemically, the education a graduate student receives is taught by faculty members, faculty craft courses based on curriculum established by the institution, and the institution uses accreditation standards stipulated by the APA to structure their curricula. Whereas research in the past has examined graduate student competency in topics of human sexuality, little research has surveyed the system closest to students, which is the faculty. To address this gap, this study examined the extent to which educators of graduate students are knowledgeable in topics of human sexuality, and how comfortable they feel integrating sexual topics into their courses.

Chapter 2: Literature Review

Relevance of Human Sexuality to Psychology

Sexual functioning is a fundamental aspect of emotional and physical health, as tribulations with sexuality can result from, or contribute to, deficits in emotional, physical, or psychological well-being (Risen, 1995; Reissing & Di Giulio, 2010; Wiederman & Sansone, 1999). While sexual health concerns can present as primary problems, they can also be secondary to physical or mental health concerns (Byers & Miller, 2008; Hanzlik & Gaubatz 2012; Reissing & Di Giulio, 2010). The following sections highlight the relationship between sexuality and the presenting concerns often encountered by clinical psychologists.

Sexual Dysfunction and Comorbid Conditions

Sexual Dysfunction is defined in the Diagnostic and Statistical Manual of Mental Disorders – Five (DSM-5) as, "a heterogeneous group of disorders that are typically characterized by a clinically significant disturbance in a person's ability to respond sexually or to experience sexual pleasure" (APA, 2013, p. 423). Practicing clinical psychologists are likely to encounter clients who experience sexual dysfunction, as Wiederman and Sansone (1999) suggested that sexual problems as a class may be second in prevalence only to substance abuse related problems. As many as 43% of women and 31% of men may be impacted by sexual concerns (Laumann, Paik, & Rosen, 1999), with significantly higher rates among clients in mental and physical health care settings (Wylie, Steward, Seivewright, Smith & Walters, 2002; as cited in Reissing & Di Giulio, 2010). The high prevalence of sexual dysfunction in mental and physical health care settings can likely be attributed to the overlapping relationship between psychological / physical well-being and healthy sexual functioning (Risen, 1995; Reissing & Di Giulio, 2010; Wiederman & Sansone, 1999).

According to the DSM-5 (APA, 2013), there are a number of factors that can influence sexual dysfunction to varying degrees. The influencing factors are broken down into five subsections. The first two subcategories entail influencing aspects specific to interpersonal elements. Subsection one is referred to as "partner factors" and includes factors specific to one's partner including partner's sexual difficulties, and partner's physical health (APA, 2013). The second subsection is referred to as "relationship factors", and includes factors such as poor communication and discrepancies in desire for sexual activity (APA, 2013). These two subcategories are encountered clinically as research has shown that couples seeking marital counseling are likely to require discussions pertaining to sexual functioning while in therapy (Bulow, 2009).

The third subcategory, "individual factors" differs from the first two in that it is not dependent on interpersonal factors, but rather individual factors that influence sexual functioning. This subcategory includes factors such as poor body image, history of abuse, psychiatric disorders, or relevant stressors, such as job loss or bereavement (APA, 2013). In regard to psychiatric disorders, research has shown that individuals diagnosed with mood or anxiety disorders are likely to experience concurrent concerns with their sexual functioning (APA, 2002; APA, 2013; Laumann, Paik, Glasser, Kang, Wang, Levinson, et al, 2006; Ostman, 2008). The fourth subcategory, "cultural and religious factors," highlights systemic variables that may impact an individual's sexual functioning such as cultural or religious attitudes of sexual activity and pleasure (APA, 2013). The final subcategory of influencing factors is "medical factors" and includes medical variables that influence sexual well-being such as cardiovascular disease, or impairments within the central nervous system (APA, 2013). Also included within the medical factors category is use or abuse of prescribed medications and illicit substances. Research

indicates that individuals prescribed psychotropic medications, or individuals who abuse illicit substances, are more likely to encounter sexual dysfunction (APA, 2002; APA; 2013; Montejo, Llorca, Izquierdo, & Rico-Villademoros, 2001; Reissing & Di Giulio, 2010).

The following section outlines a variety of sexual dysfunctions listed in the DSM-5 that are comorbid with the five subcategories listed above. It is pertinent for psychologists to be aware of the correlation between influencing factors and sexual dysfunction, as it can enable the clinician to understand and treat the individual holistically. The sexual dysfunctions outlined in the DSM-5 (APA, 2013) are as follows: Delayed Ejaculation, otherwise known as "a marked delay in or inability to achieve ejaculation despite the presence of adequate sexual stimulation and the desire to ejaculate" (p. 424), Erectile Disorder, or "repeated failure to obtain or maintain erections during partnered sexual activities" (p. 427), Female Orgasmic Disorder, described as "clinically distressing difficulty experiencing orgasm and / or markedly reduced intensity of orgasmic sensations" (p. 430), Female Sexual Interest/Arousal Disorder, described as "lack of, or significantly reduced, sexual interest/arousal" (p. 433), Male Hypoactive Sexual Desire Disorder, described as "persistently or recurrently deficient or absent sexual/erotic thoughts or fantasies and desire for sexual activity" (p. 440), and finally Premature (Early) Ejaculation, described as "a persistent or recurrent pattern of ejaculation occurring during partnered sexual activity within approximately one minute following vaginal penetration and before the individual wishes it" (p. 443).

According to the DSM-5, medical illness or injury such as diabetes mellitus, cardiovascular disease, multiple sclerosis, spinal cord injury or thyroid dysfunction, as well as substance use of either prescribed medication or illicit substances has been correlated with Delayed Ejaculation, Erectile Disorder, Female Orgasmic Disorder, Female Sexual

Interest/Arousal Disorder, Male Hypoactive Sexual Desire Disorder, and Premature (Early) Ejaculation (APA, 2013). Similarly, psychiatric disorders such as Major Depressive Disorder and Anxiety Disorders have been correlated with Delayed Ejaculation, Erectile Disorder, Female Orgasmic Disorder, Female Sexual Interest/Arousal Disorder, and Male Hypoactive Sexual Desire Disorder (APA, 2013). Finally, social and interpersonal factors such as cultural and personal attitudes towards sexuality in addition to the presence of relational violence can influence the presence of Female Orgasmic Disorder, Female Sexual Interest/ Arousal Disorder, and Male Hypoactive Sexual Desire Disorder (APA, 2013).

In order to understand and treat clients holistically, it is imperative for clinicians to grasp the intersection between sexuality and both physical and psychological health. The movement towards integrated health care exacerbates this obligation, as clinicians will be more likely to encounter clients initially concerned with physiological complaints.

Selective Serotonin Reuptake Inhibitor Induced Sexual Dysfunction

Selective Serotonin Reuptake Inhibitors (SSRIs) are a group of medications within the antidepressant category. Within the United States, SSRIs are approved for therapeutic interventions for major depression, dysthymia, and anxiety disorders (Julien, 2011). There are six SSRIs currently available within the United States: Fluoxetine (Prozac), paroxetine (Paxil), sertraline (Zoloft), fluvoxamine (Luvox), citalopram (Celexa), and escitalopram (Lexapro). The neuronal effect of SSRIs is that the medication makes serotonin more available in the synaptic cleft which results in the activation of a significant number of the postsynaptic receptors for serotonin (Julien, 2011).

A recently published study that assessed the trend of antidepressant use in the United States between the years of 1999 and 2010 in individuals eighteen and older suggested that

approximately five percent of the population is prescribed an SSRI (Mojtabai & Olfson, 2014). This percentage may be higher in 2015 given the statistically significant increase in SSRI use that was observed between the years of 1999 to 2010 (Mojtabai & Olfson, 2014). Within the population of patients with depression who are treated with an SSRI, approximately 80% exhibit sexual dysfunction including problems with orgasm, erection, sexual interest, desire, and psychological arousal (Julien, 2011). This said, it can be difficult to differentiate between SSRI induced sexual dysfunction and sexual dysfunction secondary to depression, as depression alone can impact healthy sexual functioning (Lane, 1997). A key feature that delineates the two is the presence of sexual dysfunction prior to initiation of taking an SSRI, and cessation of sexual dysfunction once the SSRI is discontinued (Julien, 2011).

In examining specific SSRI induced sexual dysfunction, it was found that all SSRIs were associated with sexual side effects (Schweitzer, Maguire, & Ng, 2009). In particular, 20% of patients taking SSRIs experienced loss of libido, 10% of patients experienced erectile dysfunction, and 30-40% of patients experienced delayed orgasm in women and ejaculatory failure or delayed ejaculation in men (Schweitzer et al, 2009). One study demonstrated that when comparing SSRI users to bupropion and placebo groups, the SSRI group's experience of orgasmic dysfunction was three times higher, sexual arousal disorder was twice as high, and incidences of sexual desire disorder was 1.5 times as high (Schweitzer et al, 2009). SSRIs that were more recently developed, such as paroxetine and sertraline have reported higher incidences of sexual dysfunction in product labeling that is affixed to the prescription in comparison to older SSRIs such as fluoxetine (Lane, 1997). One hypothesis suggests that the greater incidence of sexual dysfunction in patients receiving paroxetine in comparison to sertraline is due to the high

potency of paroxetine on serotonin reuptake inhibition with minimal effect on dopamine reuptake inhibition (Lane, 1997).

It is imperative for clinical psychologists to be cognizant of SSRI induced sexual dysfunction. This is because if left untreated, SSRI induced sexual dysfunction could contribute to the worsening of symptoms of depression and anxiety, which may in turn challenge the individual's willingness to maintain a given medication regiment (McEnany, 1998).

Sexually Transmitted Infections

In 2013 the Center for Disease Control and Prevention (CDC) estimated that in 2008 there were more than 110 million new and existing cases of Sexually Transmitted Infections (STIs) within the United States. Specifically, the CDC estimated there are 117,000 cases of Syphilis, 270,000 of Gonorrhea, 422,000 cases of Hepatitis B, 908,000 cases of Human Immunodeficiency Virus (HIV), 1.57 million cases of Chlamydia, 3.71 million cases of Trichomoniasis, 24.1 million cases of Herpes Simplex Virus 2 (HSV-2), and 79.1 million cases of Human Papillomavirus Infection (HPV). These samples demonstrate the prevalence of STIs and the resulting likelihood that psychologists will work with a client who previously had, presently has, or is at risk for contracting an STI. In light of this likelihood psychologists must be prepared to address discussions pertaining to contraction prevention methods, as well as discussions pertaining to the physical and psychological impact that STIs can have on an individual.

Children and Adolescent Population

Topics of human sexuality can arise in a variety of ways when working with child and adolescent populations. For children growing up within the United States, messages about sex might be confusing as the media often promotes sexual imagery while American culture dictates

a more constrained perspective (Polonsky, 2009). This raises concern as research has shown that parents within the United States are generally reluctant to have in depth conversations about sexuality with their children, and thus the breadth of sexual knowledge in children and adolescents originates from media portrayals of sexuality (Polonsky, 2009). It is worrisome that children and adolescents collect knowledge regarding sexuality from television. This is because sexual content on television doubled from 1998 to 2004, and was most often portrayed as a power struggle or a manipulative tool in relationships (Kunkel, Eyal & Finnerty, 2005). Further, it was also found that within the media there are rarely discussions pertaining to condoms or STIs prior to engaging in sexual acts (as cited in Polonsky, 2009, p. 383). As a result, children and adolescents are primed with inaccuracies from the media in regard to sexuality, and thus may have a difficult time navigating their own sexual development in contrast to the glamourized sexuality that is portrayed within the media.

Topics relevant to sexuality that might arise when working with children and adolescents include, but are not limited to, labeling body parts, puberty, body image, sexual feelings, sexual experimentation, and so on. (Polonsky, 2009). Topics of sexuality are likely to arise while working with youth in light of the prevalence of sexual activity, STIs, and pregnancy in high school students. In a study conducted by the CDC titled "The Youth Risk and Behavioral Surveillance System" (2011), it was found that among high school students, 47.4% had engaged in sexual intercourse, 33.7% had engaged in sexual intercourse during the previous 3 months and of these students 39.8% did not use a condom the last time they had sexual intercourse. The survey also found 76.7% neglected to use birth control pills or Depo-Provera to prevent pregnancy the last time they had sex, and that 15.3% of high school students had already had sex with four or more people during their lifetime. Additionally, the CDC found that nearly half of

the 19 million new cases of STIs contracted each year are among individuals between the ages of 15-24. Further, in the year 2009 more than 400,000 teenage girls within the United States between the ages of 15-19 had given birth. In light of these prevalence rates, clinical psychologists working with children or adolescents are likely to face discussions pertaining to sexuality with either the child/adolescent or their guardian.

The same topics might arise when working with the guardians of children or adolescents as guardians might have questions in regard to how to address the previous listed topics within their home (Polonsky, 2009). In light of the lack of education in the topic of human sexuality that clinical psychologists receive (Hanzlik & Gaubatz, 2012; Kleinplatz, 2009; Miller & Byers, 2008; Polonsky, 2009; Weiderman & Sansone, 2009), talking directly about sexual concerns might not come easily to a clinician as theories about genital phases of development do little to assist clinicians in addressing real-world sexuality concerns of children, adolescents, and their families (Polonsky, 2009). Hence, in order to effectively engage in topics pertaining to sexuality with children, adolescents, and their parents, there must be an increase in education pertaining to the topic of human sexuality in graduate training settings.

Sexual Violence

According to the United State Department of Justice (2002), each year within the United States there are approximately 152,680 completed and attempted sexual assaults, 140,990 completed rapes, and 109,230 attempted rapes per year on individuals twelve and older. A survey conducted by the Children's Bureau (Administration on Children, Youth and Families, Administration for Children and Families) of the United States Department of Health and Human Services (2012) reported that between the years of 2008 and 2012 1,660 children ages two and younger, 8,802 children ages three to five, 10,827 cases ages six to eight, and 11,600 cases ages

nine to eleven, were exposed to sexual violence. These numbers are an approximation due to prevalence of nondisclosure of sexual violence, and as such, occurrence of sexual violence is likely higher than depicted in this projection (Finkelhor, 2009; Loeb, et al, 2002).

The impact that sexual abuse can have on sexuality depends on the nature of the abuse, the age at which the abuse occurred, and the parental response (Polonsky, 2009). Across gender, childhood sexual abuse may result in difficulties with intimacy, sexual dysfunction, and compulsive sexual behavior (Hall, 2007; Trickett & Putnam, 1993). Males who have experienced childhood sexual abuse may experience difficulties with sexual adjustment and lower sexual self-esteem (Urquiza & Capra, 1990), avoidance of sexual activity or sexually compulsive behavior (Bruckner & Johnson, 1987), fear of emotions that resemble those associated with sexual abuse or specific sexual problems such as erectile dysfunction, premature ejaculation, etc., (Hunter, 1990), and may experience conflict regarding sexual orientation and identity development (Hall, 2007). Similarly, female survivors of sexual abuse may experience sexual dissatisfaction, flashbacks, dissociation, sexual avoidance, engagement in risky sexual behaviors, and feelings of low self-worth (Hall, 2007; Lemieux & Byers, 2008; Trickett & Putnam, 1993).

Factors that Influence Hesitation

In light of the information presented in previous sections outlining the intersection between sexuality and psychological wellbeing, there are numerous benefits to addressing topics of sexuality in a therapeutic context. As sexuality is a fundamental aspect of being human, an individual's feelings towards their sexuality can greatly affect their general self-image, confidence, and emotional and psychological well-being (Hanzlik & Gaubatz, 2012; Harris & Hayes, 2008; Reissing & Di Giulio, 2010; Wiederman & Sansone 1999). Addressing human sexuality in a therapeutic context can assist an individual to explore how his or her sexuality

influences other aspects in life, and can help to negate the negative impact of the barrage of sexual messages, images and miscommunications in American culture (Harris & Hayes, 2008).

Despite the prevalence and comorbidity rates of sexual concerns in clinical populations, clinical psychologists often neglect to address this topic in treatment (Harris & Hayes, 2008; Miller & Byers, 2009; Reissing & Di Giulio, 2010). The following sections outline a selection of factors that might dissuade clinical psychologists from addressing topics of human sexuality in clinical or academic settings.

Lack of Education and Comfort

A significant factor contributing to why sexuality is not discussed in therapy is the lack of education on topics of human sexuality in clinical training programs, and the resulting discomfort (Hanzlik & Gaubatz, 2012; Kleinpatz, 2003; Miller & Byers, 2009; Reissing & Di Giulio, 2010; Wiederman & Sansone, 1999). In a study conducted by Wiederman and Sansone (1999) that surveyed training directors of all the APA-accredited doctoral programs in clinical and counseling psychology, as well as pre-doctoral psychology internship programs, it was found that only half the training programs offered some sexuality-related topics within graduate courses, and that the training offered was widely focused on working with clients who had been diagnosed with HIV, or with clients from the LGBT population. This study also found that while the majority of doctoral programs offered some training within basic assessment and intervention with clients who experience sexual dysfunction, more than one third of the programs did not provide education on typical or healthy sexual functioning (Wiederman & Sansone, 1999). Similar findings in a study conducted by Miller and Byers (2008) suggests that there has not been a change in the past decade to increase training in human sexuality. Research has demonstrated that a lack of education in the topic of human sexuality directly correlates with a

lack of comfort in addressing the topic (Dixon-Woods, Regan, Robertson, Young, Cordle, & Tobin 2002; Hanzlik & Gaubatz, 2012; Harris & Hayes, 2008; Miller & Byers, 2009; Reissing & Di Giulio, 2010). Unfortunately, discomfort with discussing human sexuality resulting from a lack of education perpetuates further discomfort with the topic (Reissing & Di Giulio, 2010). This is because clinicians with less comfort discussing human sexuality are also less likely to seek out training opportunities on these topics (Reissing & Di Giulio, 2010). This raises concern because clinicians with discomfort towards discussing human sexuality often avoid the topic in a clinical context despite its relevance to conversation (Reissing & Di Giulio, 2010; Risen, 1995).

Ethical Considerations

Clinical psychologists who are members of the APA are bound by a code of ethics. This code of ethics serves as a guideline for psychologists in times of ethical predicaments. Unfortunately, the "Ethical Principles of Psychologists and Code of Conduct" stipulated by the APA does not lend assistance on how to discuss topics of human sexuality with clients, but rather only emphasizes avoidance of sexuality as a tool to avoid exploitation of the therapeutic alliance and potential litigation as a result. More specifically, the code advises psychologists on what not to do in a professional relationship, however does not lend guidance towards how a psychologist should address such topics with clients, students, or supervisees. In particular, Section 3.02 of the Ethical Principles of Psychologists and Code of Conduct states:

> Psychologists do not engage in sexual harassment. Sexual harassment is sexual solicitation, physical advances or verbal or nonverbal conduct that is sexual in nature, that occurs in connection with the psychologist's activities or roles as a psychologist and that either (1) is unwelcome, is offensive or creates a hostile workplace or educational environment, and the psychologist knows or is told this or (2) is sufficiently severe or

intense to be abusive to a reasonable person in the context. Sexual harassment can consist of a single intense or severe act or of multiple persistent or pervasive acts. (2010)

Additionally, the following guidelines are established forbidding engagement in sexual relationships with clients:

10.05 Sexual Intimacies with Current Therapy Clients/Patients: Psychologists do not engage in sexual intimacies with current therapy clients/patients.

10.06 Sexual Intimacies with Relatives or Significant Others of Current Therapy Clients/Patients: Psychologists do not engage in sexual intimacies with individuals they know to be close relatives, guardians, or significant others of current clients/patients. Psychologists do not terminate therapy to circumvent this standard.

10.07 Therapy with Former Sexual Partners: Psychologists do not accept as therapy clients/patients persons with whom they have engaged in sexual intimacies.

10.08 Sexual Intimacies with Former Therapy Clients/Patients: (a) Psychologists do not engage in sexual intimacies with former clients/patients for at least two years after cessation or termination of therapy. (b) Psychologists do not engage in sexual intimacies with former clients/patients even after a two-year interval except in the most unusual circumstances. Psychologists who engage in such activity after the two years following cessation or termination of therapy and of having no sexual contact with the former client/patient bear the burden of demonstrating that there has been no exploitation, in light of all relevant factors, including (1) the amount of time that has passed since therapy

> terminated; (2) the nature, duration, and intensity of the therapy; (3) the circumstances of termination; (4) the client's/patient's personal history; (5) the client's/patient's current mental status; (6) the likelihood of adverse impact on the client/patient; and (7) any statements or actions made by the therapist during the course of therapy suggesting or inviting the possibility of a post termination sexual or romantic relationship with the client/patient. (2010)

In examination of the only codes pertaining to human sexuality, it can be observed that the only instruction given to clinical psychologists in relevance to human sexuality is what psychologists should avoid. Thus, the ethical code fails to speak to how to address topics of human sexuality in a manner that does not provoke potential for perceived sexual harassment. Further, despite the pertinence of human sexuality to the field of psychology, the APA as an organization encourages a sense of ignorance by omission of this area, as within 56 divisions of the APA, there is not one division dedicated to human sexuality. Since the 56 divisions of the APA are structured to address the spectrum of matters that impact psychological functioning and wellbeing, the absence of a division dedicated to human sexuality implies that human sexuality is a non-essential feature of the human experience. In light of these factors, clinical psychologists are left with no ethical or fundamental guideline for how to address topics of human sexuality within a clinical or academic setting.

The Therapeutic Alliance

Psychologists and clients alike might refrain from discussions of sexuality in an effort to avoid potential impact of the therapeutic alliance. Risen (1995) stated that when there is a discussion pertaining to sexual feelings, the therapist or client might feel that they have invited or encouraged a new element of intimacy within the therapeutic alliance that can feel both exciting

and disturbing to participants. This might raise concern for clinicians that they or the client may become aroused by the discussion, and that such arousal will permeate the relationship (Risen, 1995). This experience could stir extreme discomfort for clinicians in particular, as psychologists may feel this could provoke the ethical guidelines pertaining to sexual harassment. Additionally, a psychologist is in a position of power when working with a client, and thus the therapist might feel as if they are violating or taking advantage of their client by discussing such topics. As such, clinicians may feel that breaching the topic of sexuality might be an abuse of the position of power. Therapists might also fear they are encouraging their clients to initiate sexual advances by addressing the topic of sexuality in therapy (Risen, 1995). As the APA's Code of Ethical Principles of Psychologists and Code of Conduct does not lend assistance on how to discuss topics of human sexuality with students, supervisees, or clients, but rather only emphasizes avoidance of sexuality in these relationships, psychologists may elect to entirely avoid these topics to preserve the therapeutic alliance.

Culture and Religion

Topics of human sexuality might be avoided in clinical work in light of the taboo it holds within many cultures and religions. Despite American popular culture being saturated with hyper-sexual messages from the media, it is culturally encouraged to repress individual expression of sexuality (Stayton, 1998). In particular, high value is placed on secretiveness towards the topic with the belief that it is not appropriate to discuss sexual thoughts or behaviors (Stayton, 1998). In light of this, therapists and clients might be hesitant to address topics of human sexuality in therapy, as doing so risks disturbing the cultural norm of repression in regard to sexuality. In particular, a therapist or client might hesitate to bring up issues such as abortion, contraception, non-monogamy, extramarital affairs, and masturbation in fear of disturbing the

secretiveness reserved for such topics or the potential for personal, religious, or cultural condemnation (Ridley, 2006). Even when one's culture does not condemn a topic of human sexuality the therapist or client might be hesitant towards addressing the topic in light of apprehension that the person they are sitting across from does condemn the topic they wish to address (Ridley, 2006). Further, Risen (1995) suggested that patients might be reluctant to talk about their sexual lives with their therapist out of fear that their private thoughts or wishes are strange and/or unique to them.

Risen (1995) suggested that if the client neglects to initiate topics of sexuality, the therapist might assume that sexuality is not an issue and will not address it. This is problematic because research has shown that clients might be reluctant to reveal sexual problems, and may need a therapist's encouragement to speak about sensitive issues (Farber & Sohn, 2007; Reissing & Di Giulio, 2010; Risen, 1995). Results from a study conducted by Montejo-Gonzales et al, (1997) demonstrated this phenomenon as researchers found that 58% of primary care patients revealed sexual difficulties when asked directly about them, but only 14% reported sexual difficulties on their own. This finding supports that although patients might have a desire to address these issues, they are hesitant to initiate the discussions. As professionals charged with navigating patients through the therapeutic process, clinical psychologists need to indicate their willingness to discuss sexuality. Risen (1995) suggested that clinicians can encourage their patients to speak freely and at ease about sexuality if the therapist demonstrates ease with addressing the topic. Thus it is this dance between client and therapist, both of whom fear that initiating the topic might provoke discomfort or disturb the therapeutic alliance, that prevents constructive discussions from taking place.

Integration of Human Sexuality into Graduate Programs

Clinical psychologists are widely perceived by the public as experts in emotional and psychological functioning, however without proper training in topics of human sexuality psychologists might be just as confused and secretive about sex as their clients (Harris & Hayes, 2008; Stayton, 1998). Furthermore, they may be unable to assist their clients in light of their own anxiety and lack of knowledge (Harris & Hayes, 2008; Stayton, 1998). As education in topics of human sexuality has been associated with increased comfort addressing the area (Anderson 1986; Hays, 2002), it is highly recommended by many authors that human sexuality be taught in graduate academic settings in light of the intersection between sexuality and psychological well-being (Byers & Miller, 2008; Dixon-Woods, et al, 2002; Gill & Hough, 2007; Hanzlik & Gaubatz, 2012; Wiederman & Sansone, 1999). Clinical psychologists are bound by ethical principles (APA, 2010) to practice only within the boundaries of competence based on their education, training, supervised experience, consultation, study, or professional experience (2.01). Thus, as the topic of human sexuality is likely to arise during treatment, it would be unethical for a clinician to address concerns of sexuality without adequate knowledge. As topics of human sexuality are likely to arise during the career of a psychologist, psychologists, according to some authors, should be charged with the responsibility to be educated in the areas of human sexuality (Roberts, Borden, Christiansen, & Lopez, 2005).

Increase Knowledge and Comfort

The primary reason why human sexuality should be integrated into graduate curricula is because based on the prevalence and comorbidity rates, there is a high likelihood that a clinical psychologist will encounter clients with concerns regarding human sexuality (Byers & Miller, 2008). In particular, in a study conducted by Reissing and DiGiulio (2004) researchers found that

78% of psychologists they surveyed had been asked about sexual concerns by clients. Further, psychologists tend to be the primary referral source for other health care providers, such as physicians, for patients who present with sexual concerns (Haboubi & Lincoln, 2003). Hence, it would be beneficial to integrate topics of human sexuality into graduate training as it would increase knowledge within the topic area resulting in increased comfort discussing human sexuality (Anderson, 1986; Byers & Miller, 2008; Dixon-Woods, et al, 2002; Gill & Hough, 2007; Hanzlik & Gaubatz, 2012; Harris & Hays, 2008; Hays, 2002). Similar to how topics of diversity are integrated into graduate curricula to promote multiculturally aware clinicians, topics of human sexuality should be woven into courses to increase knowledge and comfort when encountering discussions of sexuality.

Increasing comfort with the topic of human sexuality by increasing knowledge would result in an increase in therapist initiated discussions pertaining to sexuality (Harris & Hayes, 2008). Initiating discussions of sexuality is important, as research has demonstrated that patients have a desire to talk about their concerns regarding sexuality, but might be resistant to initiate the topic (Farber & Sohn, 2007; Montejo-Gonzales et al, 1997; Risen, 1995). As clients are likely to be resistant to initiate topics of sexuality, if the topic should arise therapists must be mindful of their own non-verbal reactions during such conversations as to not inadvertently communicate to their clients that they are uncomfortable, or disapprove of what clients have disclosed (Gabbard, 2010). As the United States values a sense of secretiveness in regard to sexuality (Polonsky, 2009), clients may have a hard time disclosing matters of sexuality, and in light of their discomfort, clients could become hyper-attuned to the therapist's behavior to gage whether the therapist is receiving them well, or if the therapist is uncomfortable or disapproves. In order to gain the neutrality necessary to avoid miscommunicating discomfort or disapproval, the therapist

must gain exposure to such conversations within a clinical or academic training setting so that he or she can work through his or her own attitudes and reactions towards topics of sexuality (Ridley, 2006).

Potential Consequences

As a clinical psychologist is likely to encounter topics of human sexuality at some point in his or her career, despite the lack of training in the field, they may address such concerns without the proper training, and inadvertently risk not following good practice guidelines (Reissing & Di Giulio, 2010). Therefore, a lack in training in topics of human sexuality can result in a variety of consequences (Wiederman & Sansone, 1999). Stayton (1998) suggested that psychologists who are anxious about sexual topics or who possess negative attitudes towards such topics might unintentionally impede on progress of, or even harm clients presenting with sexual concerns. As such, while issues of sexuality can already be distressing for clients, if dealt with in an inappropriate or unsympathetic manner, health professionals risk inadvertently perpetuating the distress associated with the area of concern (Dixon-Woods et al, 2002).

As previously stated, psychologists have the ethical responsibility to practice only within the boundaries of competence based on education, training, supervised experience, consultation, study, or professional experience (APA, 2010, 2.01). Hence, in light of the high likelihood that a psychologist will encounter topics of human sexuality in his or her practice, graduate programs arguably should include topics of human sexuality in their curriculum as to better prepare psychologists to navigate the topic. Further, training in this area may be necessary in order to provide a foundation upon which a clinician can make a judgment of whether it is necessary, based on the extent of symptomology, to refer the client to a clinician with more expertise in the area. Kleinplatz (2008, 2009) argued that certified sex therapists witness many patients who have

been impacted negatively by well-intended, but poorly educated health professionals, including psychologists. For example, Kleinplatz (2009) described an instance where a man was classified as impotent and was treated for childhood origins of fear of women when the mental health professional had not considered how the man's diabetes mellitus might have impacted his sexual functioning. Similarly, without proper training, a clinician faced with a client who reports sexual dysfunction may not consider that the client's dysfunction may have resulted from the SSRI he or she is prescribed. Without proper training in considerations of sexual concerns, a therapist is more likely to inadvertently commit an error in treatment that might perpetuate the presenting problem.

Therapists without a foundation of training in the area of human sexuality might also make the error of referring the client to a sex therapist rather than providing treatment to clients who have sexual concerns that are embedded in deeper psychological or developmental issues (Miller & Byers, 2008; Montejo, Llorca, Izquierdo, & Rico-Villademoros, 2001; Ng, 2007). Whereas a referral to a sex therapist for a more complex sexual presenting problem is appropriate, if the concern is embedded in psychological or developmental issues, then treating the sexual concern separately from the presenting psychological or developmental problem might hinder therapeutic progress (Miller & Byers, 2009). Thus, receiving graduate training in sexuality will provide clinicians with the "metacompetency" to recognize whether concerns regarding sexuality are within the boundaries of their competence (Reissing & Di Giulio, 2010), or if it would be more appropriate to refer the client to a sex therapist.

Dysfunction and Healthy Development

Since World War II the field of psychology has focused widely on dysfunction-oriented framework, particularly on psychological disorders and the negative impact of environmental

stressors (Faller, 2001; Seligman & Csikszentmihalyi, 2000; Snyder & Elliott, 2005). Although this trend has bolstered psychologists' ability to understand and address dysfunction, psychologists are somewhat less knowledgeable with regard to healthy development (Seligman & Csikszentmihalyi, 2000).

Sexual knowledge includes the understanding of pathological or dysfunctional sexual functioning as well as healthy sexual development. Despite this, if psychologists are educated in topics of human sexuality, they are typically only educated on the dysfunctions associated with sexuality (Miller & Byers, 2009; Weiderman & Sansone, 1999). In particular, a study conducted by Weiderman & Sansone (1999) that evaluated APA accredited doctoral programs in counseling psychology, clinical psychology, and pre-doctoral psychology internships found that the majority of programs that addressed sexual functioning covered sexual dysfunction, yet neglected to discuss healthy sexual functioning. Miller & Byers (2009) suggested that this is also true of the majority of continuing education programs in psychology. Presenting any topic with emphasis on one end of the spectrum with neglect to the other is incomplete (Faller, 2001). As such, integration of topics of human sexuality into graduate curriculum should include sexual dysfunction as well as healthy sexual development.

Systemic Influences

Systemically, there are levels of influential factors that may contribute to why clinical psychologists lack key competencies in topics of human sexuality. As an accrediting institution, the APA arguably encourages a sense of "ignorance by omission" with regard to topics of human sexuality. First, a division for human sexuality is not included among the 56 divisions of the APA that are intended to address the spectrum of matters that impact psychological functioning. Next, the Committee on Accreditation recently published new "Standards for Accreditation for

Health Service Psychology" that does not include integration of topics of human sexuality into graduate training. Further, within the "Ethical Principles of Psychologists and Code of Conduct" stipulated by the APA, psychologists are not instructed on how to navigate topics of human sexuality with clients, supervisees, or students, but rather are instructed on what to do in order to avoid exploitation of the therapeutic alliance and potential litigation as a result. Consequently, clinical psychologists are left with no ethical or fundamental guidelines for how to address topics of human sexuality.

The APA's position on the relevance of human sexuality to the field of clinical psychology impacts psychologists' preparedness to address topics of human sexuality both in academic and clinical settings. This is because the APA establishes curriculum requirements for institutions it accredits. Attending an APA accredited institution is critical for students procuring internships and procuring an internship is critical towards qualifying for licensure as well as many positions within the field. Doctoral training programs holding or seeking this accreditation use these standards to structure their curricula. Faculty members then craft courses and compose syllabi based on graduate curriculum established by the institution. Finally, students learn what faculty members teach, which results in future clinicians and faculty members who are also ill-prepared to discuss topics of human sexuality (Figure 1).

As a result of this systemic process, topics of human sexuality are rarely taught in graduate training programs (Hanzlik & Gaubatz, 2012; Kleinplatz, 2009; Miller & Byers, 2008; Polonsky, 2009; Weiderman & Sansone, 2009), which leaves graduate students and future clinicians ill-prepared to discuss topics of human sexuality with their clients, supervisees, and students.

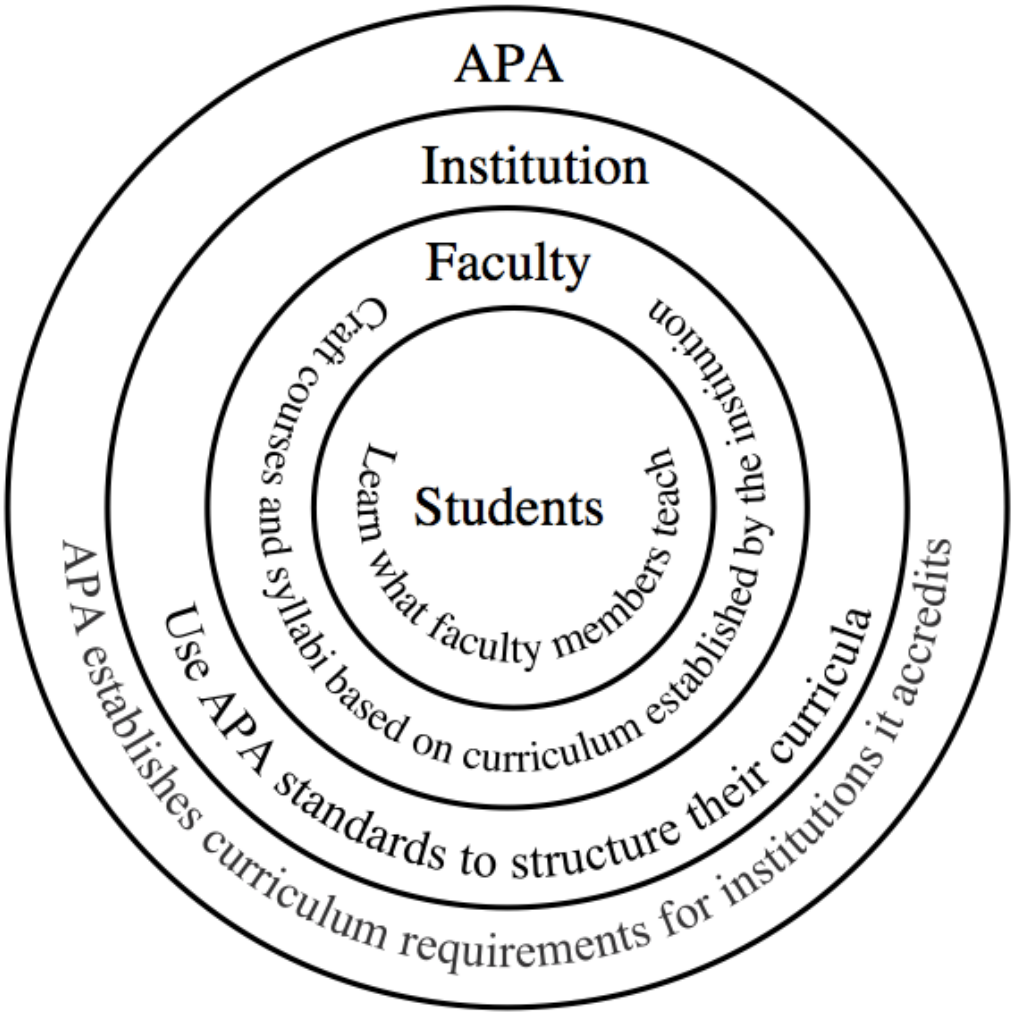


Figure 1. Systemic Influence

Conclusion

In light of prevalence and comorbidity between sexuality and psychological wellbeing, there is a high likelihood that a clinical psychologist will encounter clients with concerns pertaining to human sexuality (Byers & Miller, 2008). Despite this likelihood, research has demonstrated that clinical psychologists are often hesitant to address topics of human sexuality in session with clients (Harris & Hayes, 2008; Miller & Byers, 2009; Reissing & Di Giulio, 2010). It is possible that the hesitance psychologists experience towards discussing topics of sexuality with clients is connected to a lack of education from graduate training programs (Hanzlik & Gaubatz, 2012; Kleinplatz, 2009; Miller & Byers, 2008; Polonsky, 2009; Weiderman & Sansone, 2009). There are several studies that associated lack of training in topics of human sexuality to graduate students' lack of knowledge and comfort discussing topics of sexuality with clients (Anderson, 1986; Byers & Miller, 2008; Dixon-Woods, et al, 2002; Gill & Hough, 2007; Hanzlik & Gaubatz, 2012; Harris & Hays, 2008; Hays, 2002). Although this correlation has been demonstrated, there is a lack of research on the systemic factors driving why that knowledge is not being acquired in graduate school. As previously stated, the education a graduate student receives is taught by faculty members, faculty members craft courses based on curriculum established by the institution, and the institution uses standards stipulated by the APA for accreditation to structure their curricula. Thus, in an effort to examine this lack of knowledge and comfort systemically, this research study examined the closest systemic level to students: the faculty. Research has demonstrated that teachers who hold anxiety towards communicating sexual information were less effective educators (Harris & Hayes, 2008). As such, this study was designed to collect data on faculty competency and comfort with integrating topics of human sexuality in an academic setting.

To shed light on this area, the current study posed the following research questions:

Question 1: How much factual knowledge do faculty within the sampled APA-accredited clinical psychology doctoral programs possess regarding clinically relevant human sexuality topics?

Question 2: What level of comfort do faculty in the sampled APA-accredited doctoral programs in clinical psychology report in regard to discussing topics of sexuality with their students?

Question 3: Is the level of factual knowledge that participating faculty possess correlated with the level of comfort they report discussing topics of sexuality with their students?

Question 4: To what extent do participating faculty see sexuality as an important topic that should be integrated into graduate training?

In summary, the purpose of this study was to help determine the degree to which faculty in doctoral clinical psychology training programs are competent in human sexuality, and the degree to which they feel comfortable integrating these topics in an academic setting. The results of this study will reflect the APA's emphasis on, or lack thereof, the role of human sexuality in psychology. Ultimately, through this study we hope to foster the integration of human sexuality into doctoral training programs. It is hypothesized that faculty who are currently teaching in APA accredited clinical doctoral programs will have minimal factual knowledge regarding human sexuality, will report not feeling comfortable integrating topics of human sexuality into their curriculum, and that factual knowledge is directly correlated with comfort discussing sexuality issues with students in an academic setting.

Chapter 3: Methods

Participants

Data was collected from faculty who currently teach at an APA accredited PsyD or PhD graduate program, and who have a PsyD or PhD in clinical psychology. Additionally, for the purpose of this study participants were required to have achieved licensure as a clinical psychologist due to the assumption that if licensed, subjects will have comparable training backgrounds and qualifications. Seventy-two participants responded to outreach attempts, however sixteen participants (22%) were disqualified based on not having met the inclusion criteria. Furthermore, four participants (6%) were disqualified based on insufficient completion of surveys. Of the fifty-two subjects in this study, twenty-six (50%) identified as female, twenty-five (48%) identified as male, and one (2%) identified as "Other." The majority of participants identified as "White/Caucasian" (88%) and fell under the age of 61 (77%). Thirty-one participants (60%) reported a PhD Degree and 21 participants (40%) reported a PsyD degree. A table of the sample characteristics is listed in Table 1, and depicted in figures 2-5.

Table 1
Demographic Characteristics of Participants

Characteristics		n	%
Gender			
	Male	25	48
	Female	26	50
	Other	1	2
Age			
	30 and below	0	0
	31-36	11	21
	37-42	5	10
	43-48	10	19
	49-54	10	19
	55-60	4	8
	61 and above	12	23
Degree			
	PhD	31	60
	PsyD	21	40
Licensure Year			
	1970-1979	4	8
	1980-1989	10	19

(Table continues)

	1990-1999	10	19
	2000-2009	16	31
	2010-2014	12	23
Ethnicity			
	White/Caucasian	46	88
	African American	3	6
	Biracial/Multicultural	1	2
	No Response	2	4

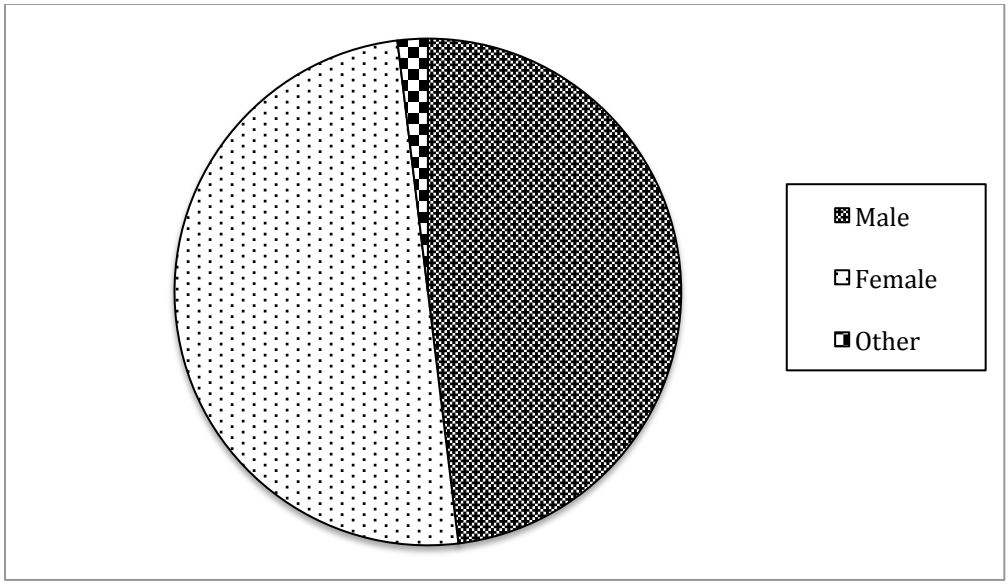


Figure 2. Gender of Participants

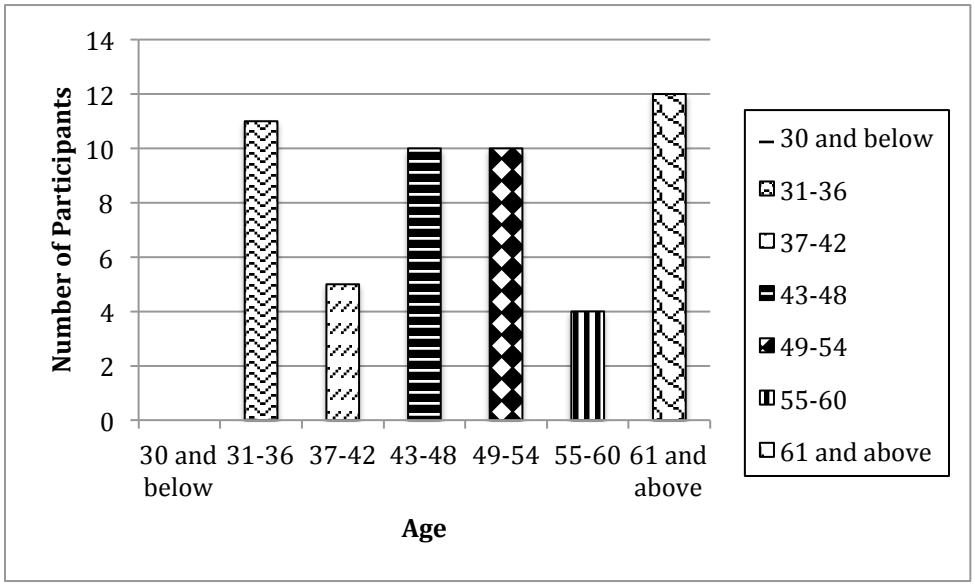


Figure 3. Distribution of Participants' Age

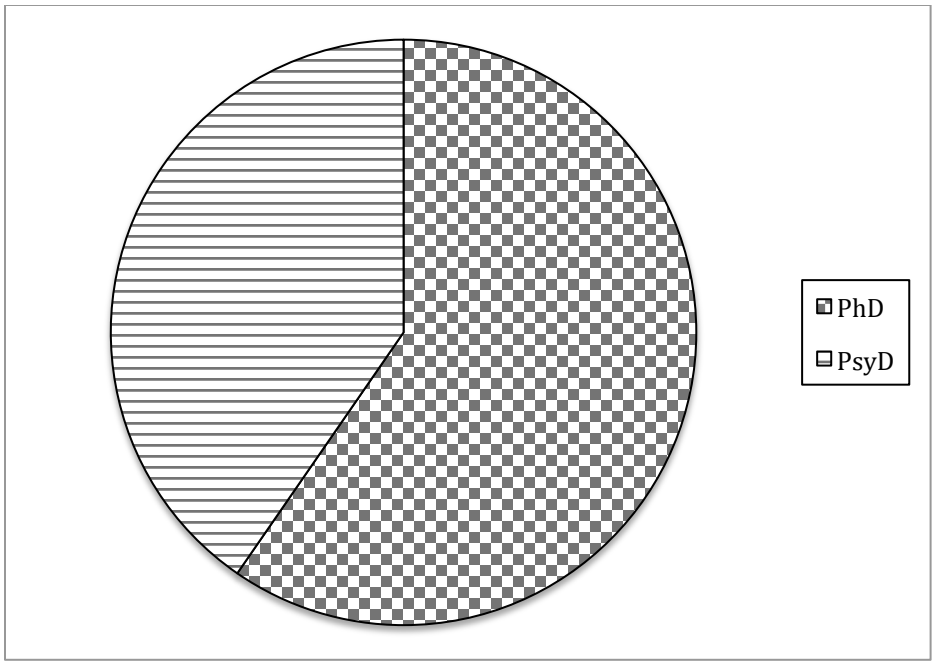


Figure 4. Participants' Credentials

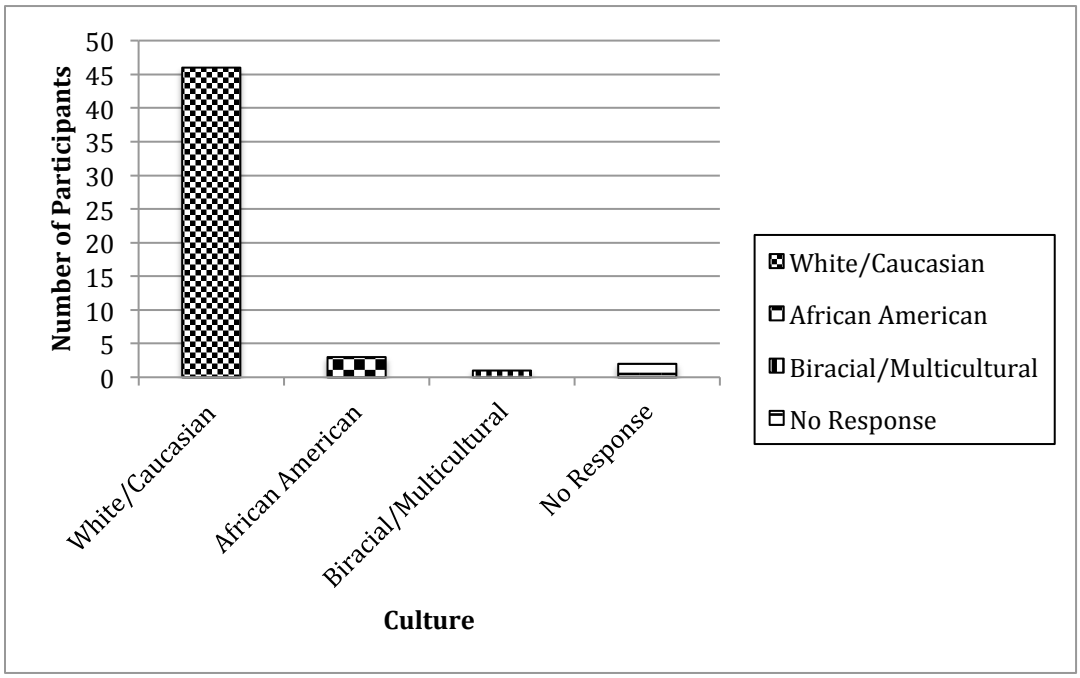


Figure 5. Participants' Culture

Procedures

Invitations to participate were disseminated through emails sent to doctoral clinical psychology program department chairs who were asked to forward the survey to faculty

members. Graduate programs were invited to participate via random sampling from a list of APA accredited graduate programs available on the APA's website. Convenience and snowball sampling was also used.

This study was conducted over the Internet through the use of the Survey Monkey© platform. Survey distribution and collection occurred from June 2014 to November 2014. Each participant was required to read and electronically sign an informed consent prior to participation. Subjects completed two primary measurements: The Faculty Sexual Comfort Scale and items from the Sexual Knowledge Questionnaire (Miller & Byers, 2009). Additionally, subjects completed a brief demographic questionnaire, and a brief list of open ended questions outlining their training in topics of human sexuality and the extent to which they value sexuality as an important topic to be integrated into academic training.

Measurements

Faculty Sexual Comfort Scale

The Faculty Sexual Comfort Scale was created by this author due to the scarcity of measures available to assess clinical psychologists' perceived level of comfort discussing topics of human sexuality in an academic setting. This measurement was formulated akin to the Clinician Sexual Comfort Scale developed by Hanzlik and Gaubatz (2012) that was originally intended to measure mental health professionals' comfort discussing matters of human sexuality in an assessment or therapy context. The Faculty Sexual Comfort Scale is comprised of 14 total items, and is divided into subscales: The Global Level of Comfort subscale (GLC), which examines faculty members' overall perceived level of comfort discussing matters of sexuality in an academic setting (question 1), and four specific level of comfort subscales, which examine faculty members' perception of comfort discussing specific sexual topics in an academic setting

(questions 2 through 14). The four subcategories of topics relevant to an academic setting include “sexual practices” (questions 2-5), “methods of contraception” (questions 6-9), “sexual dysfunction” (questions 10-12), and “alternative sex practices” (questions 13-14). Figure 6 illustrates the Likert scale and accompanying categorical descriptions found in the questionnaire. After completion of the 14 Likert scale items, participants were asked to respond to the following question in an open format, “For any of the above topics that you rated as being uncomfortable with, please describe the source of this discomfort.”

1……..2……..…3……4……..…5….....….6……..……7

Very Uncomfortable	*Uncomfortable*	*Somewhat Uncomfortable*	*Neutral*	*Somewhat Comfortable*	*Comfortable*	*Very Comfortable*

Figure 6. Level of Comfort Likert Scale

Authors Meyers & Gamst (2006) and Carifio & Perla (2008) examined the debate within the fields of behavioral and social sciences as to whether a Likert scale, otherwise known as a summative response scale, can be utilized as interval data. These authors concluded that treatment of summative response scales as interval data, particularly towards the use of parametric techniques such as Analysis of Variance (ANOVA) as well as Pearson correlation coefficients is both appropriate and useful (Carifio & Perla, 2008; Meyers & Gamst, 2006).

Sexual Knowledge Questionnaire

The Sexual Knowledge Questionnaire designed by Miller and Byers (2009) is a 14-item measurement of sexual knowledge. The measurement was originally designed based off of information from undergraduate textbooks on sexuality as well as from input from practicing psychologists. Within the Sexual Knowledge Questionnaire there are two subscales: Sexual Problems (questions 1-7) and Healthy Sexuality (questions 8-14). The Sexual Problems subscale

assesses factual knowledge of sexual conflict and dysfunction, while the Healthy Sexuality subscale measures knowledge pertaining to contraception and STIs. Each subscale is comprised of seven items, and participants engage in this questionnaire by responding in a "True" or "False" format. Reportedly, there is no validity or reliability scores available from Miller and Byers (2009).

Supplemental Measures

In addition to the Faculty Sexual Comfort Scale and the Sexual Knowledge Questionnaire, participants provided demographic information including gender, age, cultural/ethnic background, and religious/spiritual affiliation. Participants were also asked to document the year they achieved licensure, how many years they had been teaching within a doctoral clinical psychology program, what classes they typically teach, what state or US territory they currently teach within, and whether or not the institution they currently teach at offers an elective or required course in human sexuality. Participants were also asked to document the types of formal training they have received in topics of human sexuality in an open format question. Finally, participants responded to the following question in an open format, "In your opinion, how important is it that human sexuality topics be integrated within doctoral clinical psychology training?"

Chapter 4: Results

Factual Knowledge

Overall factual knowledge was determined by combining scores from the two subscales on The Sexual Knowledge Questionnaire (Miller & Byers, 2009). Scores were generated by awarding one point per correct response on each of the fourteen True/False questions. As such,

items that were skipped by participants were awarded no points, and thus were categorized as incorrect responses.

Participants demonstrated moderate to high overall sexual knowledge (M=11.25, *SD*=1.38), with composite scores ranging between 8 and 14. When scores were analyzed by subscales, participants demonstrated high knowledge of sexual problems (M= 6.33, out of seven possible items, *SD*=0.73), and moderate knowledge of healthy sexuality (M=4.92, out of seven possible items, *SD*=1.12), (Table 2).

Table 2
Means and Standard Deviations for Factual Knowledge

	PsyD & PhD		PhD		PsyD	
Variable	M	SD	M	SD	M	SD
Composite	11.25	1.38	11.07	1.40	11.52	1.37
Sexual Problems	6.33	0.73	6.32	0.75	6.33	0.73
Healthy Sexual Functioning	4.92	1.12	4.74	1.13	5.19	1.08

A dependent t-test was performed to determine whether knowledge of sexual problems and knowledge of healthy sexuality differed significantly among participants. The average score of knowledge of sexual problems was greater than knowledge of healthy sexual functioning. Participants' knowledge of sexual problems (M= 6.33, *SD*=0.73) and knowledge of healthy sexuality (M= 4.92, *SD*=1.12) differed significantly. The mean difference between populations was 1.40, and the 95% confidence interval for the estimated population mean difference is between 1.05 and 1.76. The effect size was large (*d= 1.52)*. A dependent t-test showed that the difference between subscales was significant ($t(51)=7.86$, $p < .005$, two tailed).

An independent samples t-test was performed to analyze if Overall Sexual Knowledge scores of PsyD and PhD participants differed significantly. An independent samples t-test

demonstrated that the difference between groups was not statistically significant ($t(51) = -1.18$, $p = 0.91$two -tailed). There was not a significant difference between the number of correct responses between PsyD participants (M = 11.52, *SD*=1.37) and PhD participants (M= 11.07, *SD*=1.40).

Perceived Comfort

Reported comfort was analyzed using The Faculty Sexual Comfort Scale. The Faculty Sexual Comfort Scale is comprised of fourteen total items, and is divided into five subscales: The Global Level of Comfort subscale (GLC), which examines faculty members' overall perceived level of comfort discussing matters of sexuality in an academic setting, and four specific level of comfort subscales, which examine faculty members' perception of comfort discussing specific sexual topics in an academic setting. The four subcategories of topics relevant to an academic setting include "sexual practices," "methods of contraception," "sexual dysfunction," and "alternative sex practices."

Overall, participants' GLC fell at the "comfortable" level (M= 5.98, *SD*=1.24). Forty-eight participants (92%) reported overall comfort levels of 5 ("somewhat comfortable") or higher. Participants' specific levels of comfort ranged only modestly between most subscales. On the "Alternative Sexual Practices" subscale (M = 5.64) and the "Sexual Practices" subscale (M= 5.70, *SD*=1.27) participants fell within the "Somewhat Comfortable" range. On the "Methods of Contraception" subscale (M = 6.07, *SD*=0.84) and the "Sexual Dysfunction" subscale (M = 5.99, *SD*=0.95) participants fell within the "Comfortable Range." A detailed summary of levels of comfort on items that comprise each subscale can be found on Table 3.

Table 3
Means and Standard Deviations for Faculty Comfort Scale

Variable	PhD and PsyD M	PhD and PsyD SD
Overall Comfort		
Composite	5.98	1.24
Sexual Practices		
Composite	5.70	1.27
Vaginal Intercourse	5.79	1.27
Anal Intercourse	5.46	1.49
Oral Sex	5.75	1.30
Masturbation	5.79	1.33
Contraception		
Composite	6.07	0.84
Condom	6.21	1.02
Oral Contraceptive	6.29	0.85
IUD	5.87	1.21
Abstinence	5.90	1.05
Sexual Dysfunction		
Composite	5.99	0.95
Erectile Dysfunction	5.83	1.32
Difficulty Achieving Orgasm	5.90	1.19
STDs	6.23	0.78

(Table continues)

Alt. Sexual Practices		
Composite	5.64	1.21
Non-monogamous relationships	5.96	1.08
"Alternative Practices" (e.g. bondage, S&M)	5.31	1.54

A one-way within subjects repeated ANOVA was conducted to compare the effect of perceived comfort on topic of sexuality in overall (GLC), sexual practices, methods of contraception, sexual dysfunction, and alternative sexual practices. There was a significant effect on reported comfort, $F(51) = 5.435$, $p<.0005$, $\eta^2 = .10$. Bonferroni pairwise comparison tests suggested that participants reported higher comfort levels when discussing topics of sexuality broadly (GLC) ($M = 5.98$, $SD = 0.17$) than discussing specific sexual practices ($M=5.70$, $SD = 0.18$) ($p<.05$). Additionally, participants reported higher levels of comfort discussing specific methods of contraception ($M=6.07$, $SD=0.12$) than specific sexual practices, and higher levels of comfort discussing specific methods of contraception and specific sexual dysfunctions ($M=5.99$, $SD= 0.13$) than specific alternative sexual practices ($M=5.64$, $SD = 0.17$) (Table 4).

Table 4
Intercorrelations for Reported Comfort

	Measure	1	2	3	4	5
1.	Overall Comfort	--				
2.	Sexual Practices	-.28*	--			
3.	Methods of Contraception	.09	.37*	--		
4.	Sexual Dysfunction	.01	.30	-.07	--	
5.	Alt. Practices	-.35	-.06	-.43*	-.36*	--

* Denotes significant relationship at p<.05

Correlation of Knowledge and Comfort

Pearson's *r* was utilized to assess whether participants' factual knowledge was correlated with their reported comfort levels. There was a non-significant correlation between overall factual knowledge and reported comfort *(r* = .003, N = 52, *p* >.05, one-tailed). The presence of scale attenuation, specifically a ceiling effect, likely impacted the validity of this correlation, as a large concentration of participants scored near the upper limit of the measures (Hessling, Traxel, & Schmidt, 2004). This is further addressed in the Discussion section of this study.

Perceived Importance

Participants were asked to respond the following question in an open question format, "In your opinion, how important is it that human sexuality topics be integrated within doctoral clinical psychology training?" Sixty-seven percent of participants described sexuality as being "Very" or "Highly Important." Eight percent classified it as "Vital/Extremely Important," fifteen percent classified it as "Important/Pretty Important/Key," and four percent classified it as "Fairly/Slightly Important" (Figure 7).

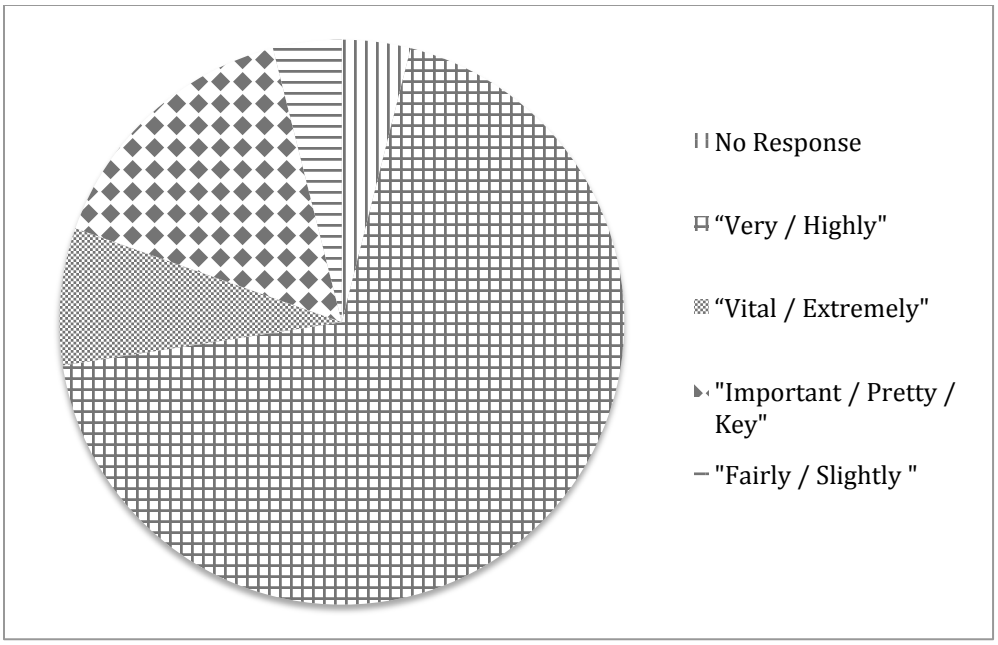


Figure 7. Perceived Importance

Perception of Discomfort

Participants were asked to respond the following question in an open question format, "For any of the above topics that you rated as being uncomfortable with, please describe the source of this discomfort." Participants' responses can be classified into five themes: knowledge, gender/sexuality, personal beliefs/religion, explicitness, and comfort with students. Approximately twenty-one percent of participants attributed their discomfort in certain items to lack of knowledge. Approximately four percent of participants attributed their discomfort to a matter of gender and/or sexuality. Approximately seven percent of participants noted religion or personal beliefs as reason for discomfort. Approximately six percent of participants noted comfort level with students as an influential factor towards discussing sexuality. Finally, approximately four percent of participants indicated that the explicitness of the topic influenced their comfort level discussing sexuality (Figure 8.)

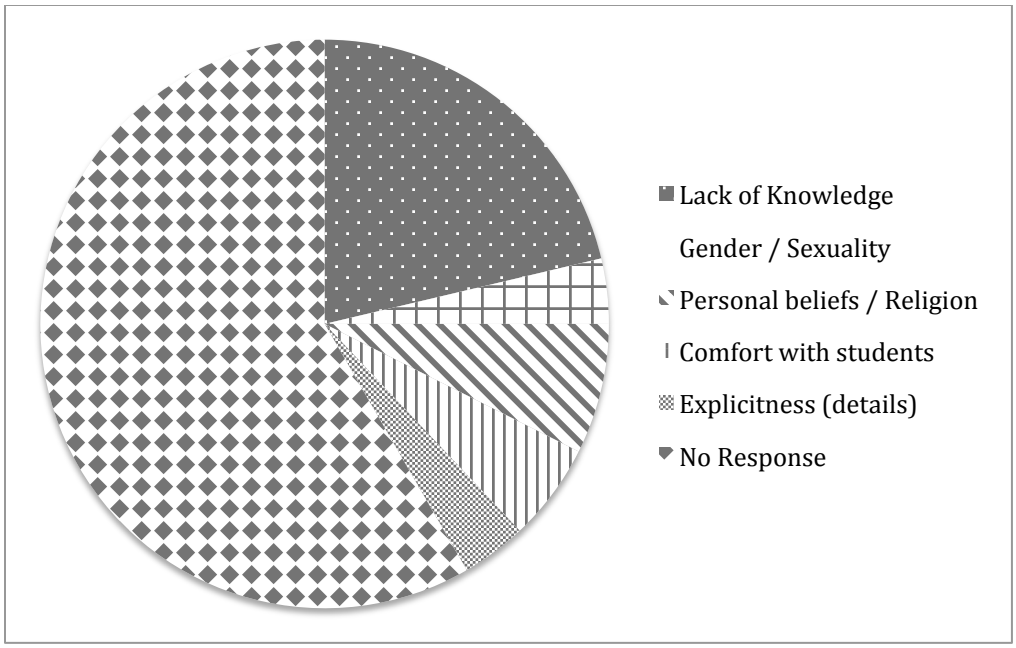


Figure 8. Perception of Discomfort

Summary

Participants demonstrated moderate overall sexual knowledge. When the results were examined by subscale, participants demonstrated high knowledge of sexual problems, and moderate knowledge of healthy sexuality. Participants conveyed significantly greater knowledge of sexual problems than knowledge of healthy sexual functioning. In regard to comfort, participants GLC fell at the "comfortable" level with specific levels of comfort ranging between subscales. In particular, participants reported comfort levels in the "Somewhat Comfortable" range in regard to "Alterative Sexual Practices" and "Sexual Practices." Participants reported comfort levels in the "Comfortable Range" with regard to "Methods of Contraception" and "Sexual Dysfunction." There was a significant difference between participants' reported level of comfort on the GLC and certain specific subscales. Particularly, participants reported greater comfort discussing topics of sexuality broadly in comparison to discussing specific sexual practices. Additionally, participants reported higher levels of comfort discussing specific

methods of contraception than specific sexual practices, and higher levels of comfort discussing specific methods of contraception and specific sexual dysfunctions than specific alternative sexual practices. A non-significant correlation was found between overall factual knowledge and reported comfort, however the presence of scale attenuation, specifically a ceiling effect, likely impacted the validity of this correlation. Finally, the majority of participants reported they believe it is "very" or "highly" important to integrate the topic of human sexuality into doctoral training.

Chapter 5: Discussion

Discussion of Results

Knowledge

The purpose of this study was to investigate faculty competency and comfort integrating topics of human sexuality into graduate curriculum. The results of this study suggest that faculty in clinical doctoral programs demonstrate moderate overall sexual knowledge and that there was not a significant difference between PsyD and PhD participants' knowledge of the assessed topics of human sexuality. When broken apart into categories, participants demonstrated significantly greater knowledge pertaining to sexual problems in comparison to healthy sexual functioning. This significant difference is reflective of the discipline's tendency to focus on dysfunction as opposed to healthy development (Faller, 2001; Miller & Byers, 2009; Seligman & Csikszentmihalyi, 2000; Snyder & Elliott, 2005; Weiderman & Sansone, 1999).

There were three "True or False" items that participants were most divided on: "The morning after pill has to be taken within 24 hours of unprotected sex (item 8)," "Condoms protect people against HPV (item 12)," and "A person can be accurately tested for HIV/AIDS within four weeks of being exposed to the virus (item 13)." It is postulated that the divide in

responses on item 13 can be attributed to ambiguous wording of the question. Specifically, participants might have been divided as it is possible to obtain an accurate positive HIV diagnosis within four weeks of being exposed to the virus, however if a negative test is achieved the patient will have to return between three to six months later to ensure the result has not been a false-negative (CDC, 2015). The ambiguity of the item suggests a need for future research to develop validated and reliable measures to assess sexual knowledge of mental health professionals.

Comfort

With regard to comfort, participants perceived themselves to be overall "comfortable" discussing topics of sexuality in an academic setting. However, when asked to examine their levels of comfort discussing specific sexually related topics, participants reported lower levels of comfort discussing specific sexual practices (e.g. vaginal intercourse, anal intercourse, oral sex, masturbation) and "alternative sexual practices" (e.g. non-monogamy, bondage, S&M, etc.). This indicates that although participants initially reported feeling comfortable discussing matters of sexuality in a classroom setting, their comfort level decreased when they were asked to envision discussing specific sexually related topics in the same setting. Still, participants maintained their perception of feeling comfortable discussing methods of contraception and sexual dysfunction. This finding echoes the trend discussed earlier of a tendency within the field of clinical psychology to focus on dysfunction as opposed to healthy sexual functioning (Faller, 2001; Miller & Byers, 2009; Seligman & Csikszentmihalyi, 2000; Snyder & Elliott, 2005; Weiderman & Sansone, 1999).

Participants were asked to respond to the following question in an open question format, "For any of the above topics that you rated as being uncomfortable with, please describe the

source of this discomfort." Participants' responses were classified into five themes: knowledge, gender/sexuality, personal beliefs/religion, explicitness, and comfort with students. Approximately twenty percent of participants attributed their discomfort in certain items to lack of knowledge. A noteworthy response within this category was, "I am not knowledgeable about this topic. I would prefer students receive better informed instruction." This participant's response agrees with the research that has demonstrated that teachers who hold anxiety towards communicating sexual information were less effective educators (Harris & Hayes, 2008). Approximately five percent of participants attributed their discomfort to a matter of gender and/or sexuality. One participant commented, "The biggest factor is probably being a man teaching in a predominantly female program" while another indicated, "As a lesbian, I am not as familiar with male sexual dysfunction." Approximately eight percent of participants noted religion or personal beliefs as reason for discomfort. For example, one participant noted, "I am somewhat uncomfortable in talking about abstinence because of its intersection with religious beliefs and moral baggage that often presages such a decision." This response echoes Ridley's argument that a psychologist might hesitate to discuss certain topics of human sexuality with a client, supervisee, or student in fear of the potential for personal, religious, or cultural condemnation (Ridley, 2006). Approximately four percent of participants indicated that the explicitness of the topic influenced their comfort level discussing sexuality. For example, one participant indicated, "…my comfortableness would increase if the conversation required details." Finally, approximately six percent of participants noted comfort level with students as an influential factor towards discussing sexuality. For example, one participant expressed, "first year first semester students, the relationship of trust not established yet." This teacher's concern that trust must first be established to discuss topics of human sexuality could represent a number

of factors that may cause hesitation among psychologists, including cultural taboo and threat to the therapeutic alliance. If trust is required to address a sensitive topic that may arise in a clinical setting, then surely that same topic should be explored in an academic context so that future clinicians are prepared to address such conversations. Further, if a sensitive topic is so poignant that it requires a sense of trust to navigate, then surely it warrants more explicit ethical and treatment guidelines than is currently made available by the APA.

Correlation Between Knowledge and Comfort

This study aimed to assess whether participants' factual knowledge was correlated with their reported comfort levels, however the presence of scale attenuation, specifically a ceiling effect, likely impacted the validity of the correlation (Hessling, Traxel, & Schmidt, 2004). In particular, participant responses in this study largely concentrated near the upper limit of the measures, and so the non-significant finding should be interpreted with caution (Hessling, Traxel, & Schmidt, 2004). Further, past studies that have examined the correlation between knowledge and comfort in other populations demonstrated a significant correlation between the two factors (Hanzlik & Gaubatz, 2012; Kleinpatz, 2003; Miller & Byers, 2009; Reissing & Di Giulio, 2010).

Perceived Level of Importance

Participants were asked to respond to the following question in an open format, "In your opinion, how important is it that human sexuality topics be integrated within doctoral clinical psychology training?" Approximately ninety percent of participants described integrating topics of human sexuality into graduate training as "vital/extremely/very/highly important." This is representative of a trend that faculty teaching in clinical doctoral programs view integrating topics of human sexuality into graduate training of high importance. Of interest to note is a point made by one participant who expressed that topics sexuality should be integrated, "As much as

can be accommodated within the already over-stuffed curriculum." Similar to the absence of an APA division dedicated to human sexuality, as well as The Committee on Accreditation neglecting to include integration of topics of human sexuality in graduate curricula as a requirement for accreditation, this participant's statement reflects the perception of human sexuality as a non-essential and secondary topic within the field of psychology.

Limitations

There are limitations to consider in this study. First, the majority of participants identified as "White/Caucasian," thus current findings may not be generalized to faculty of other ethnicities. This said, in a survey conducted by Kohout and Michalski (2009) that sampled doctoral-level APA members in Clinical, Counseling or School psychology, 88% of participants identified as Caucasian/White. As such, although results may not be generalizable to faculty members of other ethnicities, the sample is likely representative of the ethnicity distribution of doctoral-level APA members. Additionally, although this study utilized random sampling to recruit participants, a sampling bias may be present, as participants volunteered to engage in the study. This may skew results as often times voluntary response samples pull for participants who have a strong affinity for, or strong opinion pertaining to, the research topic. As such, findings regarding comfort, knowledge, and perceived level of importance may be biased based on the sample. This skew may have been reflected in the large concentration of participants who scored near the upper limit of both the knowledge and comfort measures. As noted earlier, this concentration near the upper limit of both measures likely impacted the validity of correlation findings between the two variables (Hessling, Traxel, & Schmidt, 2004). It is interesting to note however, that even in a sample of participants who likely have a strong affinity for, or a strong opinion

pertaining to the topic, there was still significantly greater knowledge pertaining to sexual dysfunction in comparison to healthy sexual functioning.

Another limitation of this study is the sample size. Faculty members were invited to participate in this study via an email that was sent to the department chair of the graduate program. Had an invitation to participate in the study been dispersed to faculty members individually, it is possible that more research participants would have been recruited.

The limited measures available in regard to sexual knowledge and comfort are also reflected in this study. The Sexual Knowledge Questionnaire (Miller & Byers, 2009) is a relatively new measure developed for previous research, and as such information regarding reliability and validity is limited. Additionally, as previously discussed, certain items on the measure are ambiguous thus risking validity. Furthermore, since The Faculty Sexual Comfort Scale was developed for this study, there is no information regarding reliability and validity of this measure. Finally, as only one measure was utilized to assess knowledge and perceived comfort, there is a risk to construct validity. Ideally, more than one measure could have been utilized to assess knowledge and comfort, however this option was not viable due to the limited number of measures available.

Implications and Directions for Future Research

An examination of the literature reveals there is a lack of validated measures designed to assess the knowledge and comfort of mental health professionals with regard to topics of human sexuality. This is problematic because assessing knowledge and comfort is an essential element towards addressing areas of growth. As such, future research should be directed towards developing and validating measures to assess knowledge and comfort among mental health professionals.

Similar to a theme found among graduate students (Hanzlik & Gaubatz, 2012), faculty teaching in graduate programs initially reported feeling overall comfortable discussing topics of sexuality, yet their perceived levels of comfort decreased when asked to address specific sexually related topics. The assumption that one is overall comfortable addressing topics of human sexuality is problematic, as it may limit motivation to seek out further training in the area. This is troublesome as it suggests that teachers may gauge themselves as feeling more comfortable addressing topics of human sexuality in an academic setting, but may become uncomfortable as certain topics arise in conversation. This is problematic, as faculty discomfort discussing topics of human sexuality may be transmitted to students' comfort addressing the topic both in the classroom and clinical setting. This perhaps contributes to why graduate students have been found to be uncomfortable addressing topics of human sexuality in previous research.

This study revealed a trend among participants that faculty in doctoral clinical psychology programs are somewhat knowledgeable and comfortable discussing sexual dysfunction, yet are less knowledgeable and comfortable discussing healthy sexual functioning. This theme embodies a tendency in the field of clinical psychology to emphasize dysfunction over healthy functioning. As sexual knowledge includes both the understanding of pathology as well as healthy development, not only should human sexuality be integrated into graduate training, but a conscious effort should also be made towards discussing healthy functioning as well as dysfunction.

There are various ways to integrate topics of human sexuality into graduate training. First, graduate institutions can offer mandatory or elective courses in topics of human sexuality. If space within curriculum cannot be negotiated for such a course, topics of human sexuality can be integrated within existing courses. Similar to how diversity is addressed across graduate courses,

human sexuality is relevant to and can be discussed in many existing courses, such as lifespan, interviewing, psychopharmacology, and so on. Further, graduate institutions could facilitate colloquia and invite guest speakers to address topics of human sexuality.

This study questioned whether the limited knowledge and comfort graduate students possess with regard to human sexuality can be attributed to systemic influences described earlier (Figure 1). This study hoped to examine this premise by examining the systemic layer most closely related to students: faculty members. Due to the limitations of this study, particularly the number of participants, sampling bias, and the available measures, in order to achieve conclusive results, further research is required. In particular, future research could focus on replication of this study with a larger sample size and validated measures.

Concluding Comments

This study found that although faculty members place high importance on integrating topics of human sexuality into graduate training, their own knowledge and comfort within the area fell only at the somewhat knowledgeable and comfortable levels in some key domains, particularly with regard to knowledge of healthy sexual development and comfort discussing specific sexual practices. Among other reasons, faculty attributed such relative deficits in their competence and comfort to insufficient education in their own training. Similar to findings from previous research, this finding supports the benefit of integrating topics of human sexuality into graduate curriculum. Nevertheless, as one participant indicated, the question of how to integrate the topic into an "already overstuffed curriculum" remains. Revisiting the systemic principle discussed throughout this study, the APA establishes curriculum requirements for institutions it accredits and institutions seeking this accreditation use these standards to structure their curricula. Faculty members then craft courses based on curriculum established by the institution, and

students learn what faculty members teach. Hence, in order for students to receive training in topics of human sexuality, the APA must accentuate the pertinence of the topic. Despite research that indicates the relevance of human sexuality to the field of clinical psychology, the APA presently implies that human sexuality is a non-essential feature of the human experience. As was discussed throughout this study, this inference is communicated through three primary means: (1) Among the 56 divisions intended to address aspects that influence psychological functioning, there is an absence of a division dedicated to human sexuality. (2) The Committee on Accreditation within the APA does not include integration of topics of human sexuality in graduate curricula as a requirement for accreditation within the newly published "Standards for Accreditation for Health Service Psychology." (3) In the "Ethical Principles of Psychologists and Code of Conduct" stipulated by the APA, psychologists are not instructed on how to navigate topics of human sexuality, but rather are instructed on what to do in order to avoid exploitation of the therapeutic alliance and potential litigation as a result. The inference that human sexuality is a non-essential feature of psychological functioning is a disservice towards psychologists, as despite the relevance of the topic, psychologists are left without guidelines for how to navigate discussions of human sexuality within a clinical and academic setting. This is particularly troublesome given the direction of integrated health care, which increases the likelihood that psychologists will encounter topics of human sexuality since psychologists would be more likely to meet with clients in a primary care setting.

The APA could cultivate a systemic shift in how the field perceives the pertinence of human sexuality by establishing a division for human sexuality, including integration of topics of human sexuality into curricula as an accreditation requirement, and by providing more directive ethical guidelines regarding how to navigate topics of sexuality with clients, supervisees, and

students. This shift in perspective would also be beneficial towards creating a venue for the development of research and potential treatment guidelines and standards of care for topics of human sexuality within the field of clinical psychology.

Graduate institutions, faculty, and students can also facilitate further education in topics of human sexuality. As an institution, programs can offer colloquia, make students aware of colloquia in the community, or offer elective courses in topics of human sexuality within course offerings. Moreover, similar to how topics of diversity are integrated throughout graduate curricula to promote multiculturally aware clinicians, faculty could weave topics of human sexuality throughout existing courses to strengthen student knowledge and comfort. Finally, students can self-advocate by seeking out training opportunities, such as colloquia or didactics, in topics of human sexuality within the community or on practicum.

Appendix A: Permission to Reproduce Copyrighted Materials

Sexual Knowledge Questionnaire (Miller & Byers, 2009)

From: Sandra Byers <byers@unb.ca>
Date: Sunday, 29 December, 2013 2:31 PM
To: Eliana Swislow <ess4206@ego.thechicagoschool.edu>
Subject: Re: Permission to use measure

I have attached the questionnaire. Please let me know if you'd like any of our other measures or any of the other publications we have in the area (I believe we have 3 others). Good luck with your research.

E. Sandra Byers
Professor & Chair
Department of Psychology
University of New Brunswick
Fredericton, NB E3B 5A3 CANADA
Telephone: 506-458-7803
FAX: 506-447-3063
http://www.unb.ca/fredericton/arts/departments/psychology/people/byers.html

From: Eliana Swislow <ess4206@ego.thechicagoschool.edu>
Date: Sunday, 29 December, 2013 2:34 PM
To: Sandra Byers <byers@unb.ca>
Subject: Re: Permission to use measure

Hello Dr. Byers,
Thank you for your quick reply, and for your permission to use the measure! I found the Sexual Knowledge Questionnaire in the manuscript, "Psychologists' Continuing Education and Training in Sexuality" published in 2009 in the Journal of Sex & Martial Therapy.
Thank you for your time and for your help!
Sincerely,
Eliana Swislow

On Dec 28, 2013, at 8:48 AM, Sandra Byers <byers@unb.ca> wrote:

Eliana--

I am happy for you to use our Sex Knowledge Questionnaire. We have different versions that we've used for different purposes. Which manuscript did you find this mentioned in?

E. Sandra Byers
Professor & Chair
Department of Psychology
University of New Brunswick
Fredericton, NB E3B 5A3 CANADA
Telephone: 506-458-7803
FAX: 506-447-3063
http://www.unb.ca/fredericton/arts/departments/psychology/people/byers.html

Appendix B: E-mail to Department Chairs to Facilitate Recruitment of Potential Participants

Dear _____,
Name of Department Chair

My name is Eliana Swislow and I am a student in the clinical psychology Psy.D program at The Chicago School of Professional Psychology. I am writing to request that your faculty participate in my dissertation research. This study examines faculty knowledge of human sexuality and comfort discussing these topics in an academic setting. Licensed clinical psychologists with a Psy.D or Ph.D. who are currently teaching in an APA accredited doctoral program in clinical psychology are eligible to participate. **It would be greatly appreciated if you would take a moment to pass this survey along to the faculty in your department.**

The study will take approximately 5-10 minutes to complete. There is no known risk associated with participation in the study. However, if participants feel uncomfortable at any time in the process, they may choose to discontinue participation in the study. *Responses remain anonymous and cannot be identified by institution.* Upon completion of the survey participants may choose to provide contact information to enter a raffle to win a $25 Amazon© gift card.

Faculty may enter the study by clicking on the following link to read the consent form:

https://www.surveymonkey.com/s/competencyeducatingsexuality

This research is being conducted in partial fulfillment of a degree requirement. If you have questions about the study please contact the principle investigator, Eliana Swislow, M.A. at ess4206@ego.thechicagoschool.edu, or the study supervisor, Dr. Braden Berkey at BBerkey@thechicagoschool.edu or (312) 467-2351.

Thank you for your time and consideration.

Sincerely,

Eliana S. Swislow, M.A
Clinical Psychology Doctoral Student
The Chicago School of Professional Psychology
ess4206@ego.thechicagoschool.edu

Appendix C: Informed Consent Form

Title: An Assessment of Competency of Doctoral Clinical Psychology Program Faculty to Integrate the Topic of Human Sexuality into Academic Training

Investigators: Eliana Swislow, M.A., under supervision of Braden Berkey, PsyD

We are asking you to participate in a research study. Please take your time to read the information below and feel free to contact the researcher with any questions before signing this document electronically by clicking "I agree" below.

Purpose: The purpose of this study is to help determine the degree to which faculty in clinical PsyD training programs are competent in human sexuality, and the degree to which they feel comfortable integrating these topics into their curriculum.

Procedures: You will be asked to fill out an online survey of approximately 30 questions. The questions will ask about your demographic information such as your age, race, and gender as well as questions that will reflect your knowledge base regarding human sexuality and your comfort with addressing these topics in an academic setting.

Completing the survey will take approximately 5-10 minutes. All survey responses are anonymous, and you will not be asked to provide any information that could personally identify you.

At the end of the survey, you will have the opportunity to enter your email address into a separate form if you wish to be entered into a drawing for a $25 gift card to Amazon©. Email addresses will be kept separate from survey data and cannot be used to identify your survey responses.

Risks to Participation: Risks of participation are minimal; however, it is possible that you might experience emotional discomfort while answering the study items and reflecting on your own training and personal beliefs regarding human sexuality.

Benefits to Participants: You will not directly benefit from this study. However, we hope the information learned from this study may benefit society by fostering the integration of human sexuality into doctoral training programs.

Alternatives to Participation: Participation in this study is voluntary. You may withdraw from study participation at any time without any penalty. If you withdraw from the study before completing the survey, your answers will not be recorded or stored.

Confidentiality: Your responses are anonymous and all study data will be kept in a secure, encrypted computer drive. No information that could link you to your responses will be collected. Data from this study will be retained securely for 5 years, per APA guidelines, and then destroyed.

Questions/Concerns: If you have any questions related to this study or would like a copy of the results when they are available, you may contact the principle or the study supervisor:

Eliana Swislow, M.A.
Ess4206@ego.thechicagoschool.edu

Braden Berkey, Psy.D.
bberkey@thechicagoschool.edu
312-467-2351

This study was approved the Institutional Review Board (IRB) of the Chicago School of Professional Psychology on 04/11/2014 If you have questions concerning your rights in this research study you may contact the which is concerned with the protection of subjects in research project. You may reach the IRB office Monday-Friday by calling 312.467.2343 or writing: Institutional Review Board, The Chicago School of Professional Psychology, 325 N. Wells, Chicago, Illinois, 60654

Subject: The research project and the procedures have been explained to me. I agree to participate in this study. I understand that my participation is voluntary, and that I may withdraw at any point in time. [subject clicks either “I agree” and is directed to first page of survey, or “I do not agree” and is redirected to a Thank You page with the researcher’s and IRB’s contact information in case they have questions]

Appendix D: Measurements

1. *Do you have a Ph.D or Psy.D in psychology? If so, please specific
   a. Psy.D
   b. Ph.D
   c. I do not have a Ph.D or Psy.D

2. Was your graduate program accredited by the American Psychological Association (APA) at the time of your matriculation?
   a. Yes
   b. No
   c. I do not know

3. *Are you licensed as a psychologist?
   a. Yes
   b. No

4. If yes, please enter the year you were licensed ____

5. *Are you currently teaching at an APA accredited clinical PsyD training program?
   a. Yes: Name of institution _____
   b. No

*Marks required question

[If subject answers "no" to any of the required questions they will be redirected to a Thank You page with the researcher's and IRB's contact information in case they have questions]

Please respond to the following item regarding your level of comfort in addressing the following topics in a classroom setting:

1. In general, how comfortable would you feel discussing clinically relevant aspects of human sexuality in a class that you teach?

1……..2……..…3……4……..…5….....….6……..……7

Very Uncomfortable	Uncomfortable	Somewhat Uncomfortable	Neutral	Somewhat Comfortable	Comfortable	Very Comfortable

How comfortable would you feel discussing the following sexually related topics in a class (when it is appropriate to do so)?

2. Vaginal intercourse

1……..2……..…3……4……..…5….....….6……..……7

Very Uncomfortable	Uncomfortable	Somewhat Uncomfortable	Neutral	Somewhat Comfortable	Comfortable	Very Comfortable

3. Anal intercourse

1……..2……..…3……4……..…5….....….6……..……7

Very Uncomfortable	Uncomfortable	Somewhat Uncomfortable	Neutral	Somewhat Comfortable	Comfortable	Very Comfortable

4. Oral sex

1……..2……..…3……4……..…5….....….6……..……7

Very Uncomfortable	Uncomfortable	Somewhat Uncomfortable	Neutral	Somewhat Comfortable	Comfortable	Very Comfortable

5. Masturbation

1……..2……..…3……4……..…5….....….6……..……7

Very Uncomfortable	Uncomfortable	Somewhat Uncomfortable	Neutral	Somewhat Comfortable	Comfortable	Very Comfortable

6. Condom use

1……..2……..…3……4……..…5….....….6……..……7

Very Uncomfortable	Uncomfortable	Somewhat Uncomfortable	Neutral	Somewhat Comfortable	Comfortable	Very Comfortable

7. Oral contraceptive

1……..2……..…3……4……..…5….....….6……..……7

Very Uncomfortable	Uncomfortable	Somewhat Uncomfortable	Neutral	Somewhat Comfortable	Comfortable	Very Comfortable

8. Intrauterine Device (IUD) use

1……..2……..…3……4……..…5….....….6……..……7

Very Uncomfortable	Uncomfortable	Somewhat Uncomfortable	Neutral	Somewhat Comfortable	Comfortable	Very Comfortable

9. Abstinence from sexual intercourse

1……..2……..…3……4……..…5….....….6……..……7

Very Uncomfortable	Uncomfortable	Somewhat Uncomfortable	Neutral	Somewhat Comfortable	Comfortable	Very Comfortable

10. Erectile dysfunction

1……..2……..…3……4……..…5….....….6……..……7

Very Uncomfortable	Uncomfortable	Somewhat Uncomfortable	Neutral	Somewhat Comfortable	Comfortable	Very Comfortable

11. Difficulty achieving orgasm

1……..2……..…3……4……..…5….....….6……..……7

Very Uncomfortable	Uncomfortable	Somewhat Uncomfortable	Neutral	Somewhat Comfortable	Comfortable	Very Comfortable

12. Sexually transmitted diseases

1……..2……..…3……4……..…5….....….6……..……7

Very Uncomfortable	Uncomfortable	Somewhat Uncomfortable	Neutral	Somewhat Comfortable	Comfortable	Very Comfortable

13. Non- monogamous relationships

1……..2……..…3……4……..…5….....….6……..……7

Very Uncomfortable	Uncomfortable	Somewhat Uncomfortable	Neutral	Somewhat Comfortable	Comfortable	Very Comfortable

14. "Alternative" sexual practices (Bondage, S&M, etc.)

1……..2……..…3……4……..…5….....….6……..……7

Very Uncomfortable	Uncomfortable	Somewhat Uncomfortable	Neutral	Somewhat Comfortable	Comfortable	Very Comfortable

15. For any of the above topics that you rated as being uncomfortable with, please describe the source of this discomfort:

_____

_____

Sexual Knowledge Questionnaire (Miller & Byers, 2009)

1. T F Masturbation can be used as part of the treatment for sexual problems/dysfunctions.

2. T F Many sexual disorders originate as the result of non-sexual elements of a couples relationship.

3. T F If a man is experiencing premature (rapid) ejaculation, it is useful for him to try to distract himself during sex.

4. T F Approximately half of individuals taking antidepressants will experience some form of sexual dysfunction related to the drug.

5. T F A man who can initially achieve an erection, but is unable to maintain it until the completion of sexual activity could be diagnosed as having an erectile dysfunction.

6. T F Married people rarely masturbate unless there are problems in the relationship.

7. T F Unless the goal of sex for both members of the couple is to reach orgasm, it is difficult to have a satisfactory sexual relationship.

8. T F The morning after pill has to be taken within 24 hours of unprotected sex.

9. T F Herpes is only contagious during an active outbreak.

10. T F Many people with Chlamydia don't have any symptoms of the infection.

11. T F Antibiotics can interfere with the effectiveness of birth control pills.

12. T F Condoms protect people against HPV.

13. T F A person can be accurately tested for HIV/AIDS within four weeks of being exposed to the virus.

14. T F After a vasectomy sexual desire may diminish slightly because the male hormones are no longer generated in the testes.

Please provide some information about yourself (This information will be kept confidential)

Age:

a. 30 and under
b. 31-36
c. 37 – 42
d. 43-48
e. 49-54
f. 55-60
g. 61+

Gender: Male / Female / Other

Cultural /Ethic Background**:** _____
Religious/Spiritual Affiliation**:** _____

What types of formal training have you had in the topic of human sexuality (e.g., coursework, workshops, continuing education, clinical/counseling rotations, practica)?

_____
_____

In your opinion, how important is it that human sexuality topics be integrated within doctoral clinical psychology training.

_____
_____

How many years have you been teaching within a doctoral level psychology program?
_____

What class subjects do you typically teach at the doctoral level?
_____
_____

To your knowledge, does the school at which you currently teach at offer a course in human sexuality for students at the doctoral training level? Yes/No

If so, is it a required or elective course?
Required/Elective/Not Applicable – my school does not offer a course in human sexuality.

What state or US territory do you currently teach within? _____

References

Anderson. W. (1986). Stages of therapist comfort with sexual concerns of clients. *Professional Psychology: Research and Practice*. 17. 352-356.

American Psychological Association. (2010). Ethical principles of psychologists and code of conduct. *American Psychologist, 57(12),* 1060–1073.

American Psychological Association. (2009). *Divisions of the American Psycho- logical Association.* Retrieved from http://www. apa.org/about/ division. Html

American Psychological Association. (2015). Standards of Accreditation for Programs in Health Service Psychology. Retrieved April 30, 2015, from http://www.apa.org/ed/accreditation/about/policies/standards-of-accreditation.pdf

Bandura, A. (1969). *Principles of behavior modification.* New York: Holt.

Bartoi, M. G., & Kinder, B. N. (1998). Effects of child sexual abuse on adult sexuality. *Journal of Sex & Marital Therapy, 24,* 75–99.

Bridges, S. K., Lease, S. H., & Ellison, C. R. (2004). Predicting sexual satisfaction in women: Implications for counselor education and training. *Journal of Counseling & Development, 82* 158–166.

Bruckner, D. F., &Johnson, P. E. (1987). Treatment for adult male victims of childhood sexual abuse. Special Issue: Child sexual abuse. Social carnuork, 68,81-87.

Bulow, S. (2009). Integrating sex and couples therapy: A multifaceted case history. Family Process, 48, 379-389.

Centers for Disease Control and Prevention (2011). Youth Risk Behavior Surveillance – United States 2011. MMWR 2012, 61

Carifio, J., & Perla, R. (2008). Resolving the 50-year debate around using and misusing Likert

scales. Medical Education, 48, 1150-1152.

Center for Disease Control and Prevention (2015). HIV Testing in Clinical Settings. Retrieved March 13, 2015, from http://www.cdc.gov/hiv/testing/clinical/index.html

Center for Disease Control and Prevention (2015). Incidence, Prevalence, and Cost of Sexually Transmitted Infections in the United States. Retrieved March 8, 2015, from http://www.cdc.gov/std/stats13/default.htm

Davis, M. & Niebes-Davis, A. (2010). Ethnic differences and influence of perceived future certainty on adolescent and young adult sexual knowledge and attitudes. Health, Risk & Society, 12, 149–167.

Department of Justice. (2002). Sexual Assault. Retrieved March 14, 2015, from http://www.justice.gov/ovw/sexual-assault

Diagnostic and statistical manual of mental disorders: DSM-IV-TR. (4th ed.). (2000). Washington, DC: American Psychiatric Association.

Diagnostic and statistical manual of mental disorders: DSM-5. (5th ed.). (2013).Washington, D.C.: American Psychiatric Association.

Diiock, P. T. (1988). Adult males sexually abused as children: Characteristics and implications for treatment. Jamal of Intrsonal Vii 9203-221.

Dixon-Woods, M., Regan, J., Robertson, N., Young, B., Cordle, C., & Tobin, M. (2002). Teaching And Learning About Human Sexuality In Undergraduate Medical Education. *Medical Education*, *36*(5), 432-440.

Dhaliwal, G. K., Gauzas, L., Antonowicz, D. H., & Ross, R. R. (1996). Adult male survivors of childhood sexual abuse: Prevalence, sexual abuse characteristics, and long-term effects. *Clinical Psychology Review, 16,* 619-639. Retrieved October 5, 2007, from Academic Search Premier Database.

Faller, G. (2001). Positive Psychology: A Paradigm Shift. *Journal Of Pastoral Counseling*, *36*7.

Farber, B. A., Berano, K. C., & Capobianco, J. A. (2004). Clients' Perceptions Of The Process And Consequences Of Self-Disclosure In Psychotherapy.. *Journal of Counseling Psychology*, *51*(3), 340-346.

Farber, B. & Sohn, A. (2007). Patterns of self-disclosure in psychotherapy and marriage. Psychotherapy: Theory, Research, Practice, Training, 44, 226-231.

Finkelhor, D. (2009). The Prevention of Childhood Sexual Abuse. *The Future of Children,* 169-194.

Fyffe, A. E., & Tian, P. S. O. (1979). Influence of modeling and feedback provided by the supervisors in micro skills training program for beginning counselors. *Journal of Clinical Psychology, 35,* 651–656.

Gabbard, G. (2010). *Long-Term Psychodynamic Psychotherapy: A Basic Text.* American Psychiatric Publications

Gill, K. & Hough, S. (2007). Sexuality training, education and therapy in the healthcare environment: Taboo, avoidance, discomfort or ignorance? Sexuality and Disability, 25, 73-76.

Haboubi, N. H., & Lincoln, N. (2003). Views of health professionals on discussing sexual issues with patients. Disability and Rehabilitation, 25,291–296.

Hall, K. (2007). Sexual dysfunction and childhood sexual abuse: Gender differences and treatment implications. In S. R. Leiblum (Ed.), Principles and practice of sex therapy (pp. 313-349). New York: The Guilford Press.

Hanzlik, M. P., & Gaubatz, M. (2012). Clinical PsyD Trainees' Comfort Discussing Sexual Issues with Clients. *American Journal of Sexuality Education* , 7(3), 219-236.

Harris, S. M., & Hays, K. W. (2008). Family therapist comfort with and willingness to discuss client sexuality. Journal of Marital and Family Therapy, 34, 239–250.

Hartmann, U., Philippsohn, S., Heiser, K., & Ruffer-Hesse, C. (2004). Low sexual desire in midlife and older women: Personality factors, psychosocial development, present sexuality. *Menopause: The Journal of The North American Menopause Society*, 11(6), 726–740.

Hays, K. (2002). The influence of sexuality education and supervision, clinical experience, perceived sex knowledge, and comfort with sexual content on therapists addressing sexuality issues with clients. Dissertation Abstracts International Section A: Humanities and Social Sciences

Heiman, J. R. (2002). Sexual dysfunction: Overview of prevalence, etiological factors, and treatments. *The Journal of Sex Research*, 39(1), 73–78.

Hessling, R., Traxel, N., & Schmidt, T. (2004). Ceiling effect. In M. Lewis-Beck, A. Bryman, & T. Liao (Eds.), *Encyclopedia of social science research methods.* (pp. 106-107). Thousand Oaks, CA: SAGE Publications, Inc.

Horowitz, A. V., Spatz Widom, C, McLaughlin, J., & Raskin White, H. (2001). The impact of childhood abuse and neglect on adult mental health: A prospective study. *Journal of Health and Social Behavior*, 42, 184-201.

Hunter, M. (1990). Abused boys the neglected victims of sexual abuse Lexington, MA: Lexington Books & D. C. Heath and Company.

Julien, R. M. (2011). *A primer of drug action: a comprehensive guide to the actions, uses, and side effects of psychoactive drugs* (12th ed.). New York, NY: Palgrave Macmillan.

Kleinplatz, R. (2003). What's new in sex therapy? From stagnation to fragmentation. Sexual and Relationship Therapy, 18, 95-106.

Kleinplatz, P. J. (2008). The profession of sex therapy. In K. Hertlein, G. Weeks, & N. Gambescia (Eds.), Systemic sex therapy (pp. 21–41). New York: Routledge.

Kleinplatz, P. (2009). Consumer protection is the major purpose of sex therapy certification. Archives of Sexual Behavior, 38, 1031-1032.

Kohout, J., Michalski, D. (2009). 2008: APA Survey of Psychology Health Service Providers. Retrieved March 1, 2015, from http://www.apa.org/workforce/publications/08-hsp/index.aspx?tab=1

Lane, R. (1997). A critical review of selective serotonin reuptake inhibitor-related sexual dysfunction; incidence, possible aetiology and implications for management. *Journal of Psychopharmacology*, *11*, 72-82.

Laumann, E. O., Paik, A., Glasser, D. B., Kang, J., Wang, T., Levinson, B., et al. (2006). A cross-national study of subjective sexual well-being among older women and men: Findings from the global study of sexual attitudes and behaviors. Archives of Sexual Behavior, 35(2), 145-161.

Lemieux, S., & Byers, E. (2008). The Sexual Well-Being of Women Who Have Experienced Child Sexual Abuse. *Psychology of Women Quarterly,* 126-144.

Loeb, T., Williams, J., Carmona, J., Rivkin, I., & Wyatt, G. et al. (2002). Child sexual abuse: associations with sexual functioning of adolescents and adults. *Annual Review of Sex Research*,13,307-345.

Lykins, A. D., Janssen, E., & Graham, C. A. (2006). The relationship between negative mood and sexuality in heterosexual college women and men. *Journal of Sex Research, 43,* 136–143

Marmor, J. (1971). "Normal" and "deviant" sexual behavior. *Journal o the American Medical Association,* 217, 165-170.

McEnany, G. (1998). Sexual Dysfunction in the Pharmacologic Treatment of Depression: When "Don't Ask, Don't Tell" Is an Unsuitable approach to Care. *Journal of the American Psychiatric Nurses Association*, 4, 24-29.

Meyers, L., & Gamst, G. (2006). *Applied multivariate research: Design and interpretation*. Thousand Oaks: Sage Publications.

Miller, S. A., & Byers, E. S. (2008). An exploratory examination of the sexual intervention self-efficacy of clinical psychology graduate students. Training and Education in Professional Psychology, 2, 137–144.

Miller, S. A., & Byers, E. S. (2009). Psychologists' continuing education and training in sexuality. Journal of Sex & Marital Therapy, 35, 206–219.

Mojtabai, R., & Olfson, M. (2013). National Trends in Long-Term Use of Antidepressant Medications. *J. Clin. Psychiatry The Journal of Clinical Psychiatry, 75*(2), 169-177.

Montejo-Gonzales, A. L., Liorca, G., Izquierdo, J. A., Ledesma, A., Bousono, M., Cal- cedo, A., . . . (1997). SSRI-induced sexual dysfunction: Fluoxetine, paroxetine, sertraline, and luvoxamine in a prospective, multicenter, and descriptive clinical study of 344 patients. *Journal of Sex and Marital Therapy*, 23, 176–194. Retrieved from EJE E-Journals database.

Montejo, A. L., Llorca, G., Izquierdo, J. A., & Rico-Villademoros, F. (2001). Incidence of sexual dysfunction associated with antidepressant agents: A prospective multicenter study of 1022 outpatients. *Journal of Clinical Psychiatry*, 62, 10–21.

Ng, J. S. C. (2007). Sexuality and psychotherapy: An exploratory study of the subjectivities of psychotherapists with experience and expertise in working with sexuality. *Dissertation Abstracts International*, 67, 9B.

Polonsky, D. (2009). Counseling children, adolescents, and their families about sexual issues. In Balon, R. & Segraves, R. (Eds.), Clinical manual of sexual disorders (p. 371-401). Arlington, VA: American Psychiatric Publishing, Inc.

Reissing, E. & Di Giulio, G. (2010). Practicing clinical psychologists' provision of sexual health care services. Professional Psychology: Research and Practice, 41, 57-63.

Ridley, J. (2006). The subjectivity of the clinician in psychosexual therapy training. Sexual and Relationship Therapy, 21, 319-331.

Risen, C. B. (1995). A guide to taking a sexual history. *Psychiatric Clinics of North America*, 18, 39-53. Retrieved October 5, 2007, from Academic Search Premier database

Roberts, M., Borden, K., Christiansen, M., & Lopez, S. (2005). Fostering a culture shift: Assessment of competence in the education and careers of professional psychologists. Professional Psychology: Research and Practice, 36, 355-361.

Seligman, M., & Csikszentmihalyi, M. (2000). Positive Psychology: An Introduction. *American Psychologist,* 5-14.

Schweitzer, I., Maguire, K., & Ng, C. (2009). Sexual side-effects of contemporary antidepressants: review. *Australian and New Zealand Journal of Psychiatry*, 43(9), 795-808.

Snyder, C., & Elliott, T. (2005). Twenty-First century graduate education in clinical psychology: A four level matrix model. *Journal of Clinical Psychology,* 1033-1054.

Stayton, W. (1998). A curriculum for training professionals in human sexuality using the Sexual Attitude Restructuring (SAR) model. Journal of Sex Education & Therapy, 23, p. 26-32.

Trickett, P. K., & Putnam, F. W. (1993). Impact of child sexual abuse on females: Toward a developmental psychobiological integration. *Psychological Science*, 4(2), 81-87.

Urquiza, A. J.. & Capra, M. (1990). The impact of sexual abuse: Initial and long-term effects. In M. Hunter (Ed.), The sexually abuse male. Vol. 1:Prevelance, impact, and treatment. (pp.105-136). Lexington,MA: Lexington Books & D.C Health and Company

Wiederman, M. W., & Sansone, R. A. (1999). Sexuality training for professional psychologist: A national survey of training directors of doctoral programs and predoctoral internships. Professional Psychology: Research and Practice, 30, 312–317.

World Health Organization (2006). *Defining sexual health: Report of a technical consultation on sexual health 28-31 January 2002, Geneva*. Geneva, Switzerland: WHO Press.

.