

THE FACTORS THAT INFLUENCE THERAPIST COMFORT IN TALKING WITH  
ADOLESCENTS AND THEIR PARENTS ABOUT SEXUALITY

by

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(Under the Direction of Edward Delgado-Romero)

ABSTRACT

The purpose of this study is to examine what factors may allow therapists to feel more comfortable facilitating a discussion between parents and their adolescents about sex. The specific factors that are used in this study are therapist training, ethnocultural empathy, and sexual values. Participants were students and practicing clinicians in various mental health professions: counseling, clinical and counseling psychology, marriage and family therapy, and social workers. They filled out the following instruments through an online survey website: demographic questionnaire; Scale of Ethnocultural Empathy (Wang, et al. 2003); and Therapists' Sexual Values Scales (Ford & Hendrick, 2003). The results indicated that for White therapists, the more satisfied the therapist is with the sexuality training they received and the more liberal their sexual values, the higher their comfort with facilitating a discussion between adolescent's and their parents about sexuality. For therapists of color, the more liberal their sexual values the more comfortable they are with facilitating a discussion between adolescent's and their parents about sexuality.

INDEX WORDS: Adolescent Sexuality, Therapist Training, Cultural Empathy, Sexual Values

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## DEDICATION

I would like to dedicate this to the teen parents of the Clarke County Early Head Start/Head Start program. The numerous conversations with you all about relationships and sexuality motivated me to do this research.

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First and foremost, I want to acknowledge God. Without the Lord I would not have come this far and would not be able to continue pursuing my goals. Thank you.

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## CHAPTER 1

### INTRODUCTION

#### *Researcher's Professional and Personal Investment in the Research*

This particular project was chosen for a number of reasons. As a graduate assistant this researcher worked with teenage mothers in the Clarke County Early Head Start/Head Start program for five years. During that time this researcher had numerous conversations with the young women about such topics as: their decisions to have sex, use/lack of use of contraception, the conversations they had with their parent(s) about sex, and what was their experience of sex education in school. The researcher learned that these adolescents for varied reasons rarely had conversations with their parents about sex or learned anything in school outside of abstinence. Given that these young women were having children at the age of 13 it was apparent that abstinence was not effective and this fact intrigued the researcher. As a future psychologist this researcher began to wonder what a therapist could do to prevent teen pregnancy. Most therapists will encounter a parent who wants to talk with their child about sex or a child who wants to talk with their parent about sex. From a prevention perspective, this researcher believes that if therapists can facilitate healthy discussions about sex between parents and children then perhaps the rate of teenage pregnancies and sexually transmitted infections will decrease. However, in order for that conversation to happen therapists have to first feel comfortable facilitating these discussions and possess cultural sensitivity and appreciation of sexuality at all ages.

### *The Problem*

In 1991, 54.1 percent of teens reported having sex, while in 2003 that number dropped to 46.7 percent (Manlove, Papillio & Ikramullah, 2004). While those numbers may seem encouraging, according to Amaro, Raj, and Reed (2001), statistics in 2000 state that the majority of youth that have HIV are adolescent girls and that 1 in 10 adolescent girls have the sexually transmitted infection (STI) Chlamydia. Other statistics from 2003 show that while 1 in 5 teens reports having sex before the age of 15, almost half of the high school students surveyed are experienced sexually and by the time these students graduate high school 6 out of 10 will have had sex (Manlove, Papillio & Ikramullah, 2004). According to the Youth Risk Behavior Surveillance Survey conducted in 2005 by the Centers for Disease Control and Prevention (CDC): 46.8% of 13,917 teens surveyed nationwide had had sexual intercourse; 33.9% were currently sexually active; and 14.3% had sexual intercourse with at least four people in their lifetime. Locally in Athens-Clarke County, a similar 2005 survey conducted among 1,926 high school age students (age 14+) reports that 46% of students were sexually active and 49% of those students have had at least three sexual partners (BART, 2005). Given the high level of teens engaging in sexual activity, researchers concerned about prevention want to know where teens learn about sex. More specifically, Nation and colleagues (2003) state that a community's norms, cultural beliefs, and practices should be incorporated into the content, delivery and evaluation of any prevention program. Thus, if researchers want to have a better understanding of the sexual outcomes of adolescents, researchers should learn the cultural norms and values that underlie adolescents' sexual behavior and knowledge (Deardorff, Tschann & Flores, 2008). The cultural norms and values related to adolescent sexual values include, but are not limited to: where teens

learn about sex, what they are learning, and what parents know and are sharing with their adolescents about sex.

According to a study by Somers and Surmann (2004) adolescents are learning about sex from their peers, parents, and siblings, school and the media. Bleakley and colleagues (2009) report that of all television programs popular among adolescents, 83% of these programs include sexual content. There are also educational articles about teen pregnancy, contraceptive use, and other sexual topics in magazines and websites targeting adolescents (Bleakley et al, 2009). In addition, adolescents can access information on sex and sexuality on the internet via sex education websites, chat rooms, pornography, inaccurate/distorted information, and email (Bleakley et al., 2009). However, the Somers and Surmann study reports that regardless of difference (e.g., grade, race and gender) included in their study, adolescents primary preferred source for adolescents to learn about sex is parents (2004).

Adolescents and their parents are often too embarrassed to communicate about sex (Hetsroni, 2008; Miller, et al., 1998). In many cases parents have a hard time accepting that their adolescents are becoming or potentially becoming sexually active so they choose to ignore what may be happening. On the other hand, adolescents also find it difficult to think of their parents as sexual beings (Byers et al., 2003; Hetsroni, 2008). As a result there is no communication about sex, yet the adolescents want the information and their parents want them to have the information to prevent sexual activity, teen pregnancy or contracting a sexually transmitted infection.

Parents often know very little about sexual health or have been misinformed. A number of parents admit that they have no idea where to find out about the most current information on sexual health. They also admit that they are not comfortable talking with their teens about sex.

Their lack of comfort may be a result of lack of knowledge, being unsure of what to say, and no role models to show them how to have conversations about sex (Guilamo-Ramos, et al, 2006).

Informing parents and increasing comfort in talking about sex is where the therapist can be helpful. According to surveys from the O'Donnell and colleagues (2007) parents are interested in receiving support from schools, healthcare providers (i.e., therapists) and community organizations in dealing with the challenges of adolescents. Therefore, one role of the therapist may be educating parents and/or helping parents become more comfortable speaking with their adolescents about sex. Taking into account factors such as religious beliefs, gender roles, and other cultural norms, the therapist may educate the parents about sexual health, provide the parents with literature, and role play with the parents a conversation about sex. It is important for parents and therapists to remember that communication and education about sexuality must go beyond the physical and emotional consequences of engaging in sexual behavior and include information about healthy attitudes, norms, and values about sexuality (Bleakley, et al., 2009).

### *Purpose*

The purpose of this study is to examine what factors may allow therapists to feel more comfortable facilitating a discussion between parents and their adolescents about sex. The specific factors that are used in this study are ethnocultural empathy and sexual values.

Ethnocultural empathy, as defined by Wang and colleagues (2003) is empathy that is directed toward people from racial and ethnic cultural groups who are different from one's own ethnocultural group. For the purposes of this study sexual values are described as beliefs, opinions, and attitudes held by someone about sexuality. There have been studies that focused on therapist sexual values in working with clients across the lifespan (e.g., Ford & Hendrick, 2003)

but none that address a therapist's sexual values when specifically working with adolescents. There have also been studies that focus on therapist's ethnocultural empathy (Wang, et al., 2003) but none that address how ethnocultural empathy impacts a therapist's ability to facilitate a discussion about sex between parents and adolescents. Many studies were found that provide valuable information on the experiences of sexuality in different populations and some of those studies included important information on how therapists could help but none of those studies address the role of ethnocultural empathy and sexual values in the role of the therapist. This study is seeking to examine the factors that have not been previously addressed in the literature.

### *Importance to Counseling Psychology*

Therapist comfort with facilitating discussions with parents and adolescents about sexuality is important to the field for a number of reasons. Counseling psychologists value social justice, diversity and prevention (Reese & Vera, 2007). In 2003 Ivey and Collins stated that it was essential for counseling psychology to take on an upstream preventive approach, meaning that operating from a multicultural and social justice framework our profession should pay more attention to psychoeducation, community psychology, and prevention. Reese and Vera (2007) state that counseling psychology has an emphasis on prevention and combined with the field's expertise in multicultural competence, when working with psychologists and professionals from other specialties, there is the possibility to address the need of culturally relevant prevention programs. Additionally, Constantine (2000) stated, "counselors who successfully communicate a sense of caring and understanding regarding the experiences of their culturally diverse clients may be perceived by these clients as multiculturally competent" (p.868). If counseling psychologists are going to contribute to the important values of the profession they should



possess ethnocultural empathy and/or feel comfortable talking with parents and/or adolescents about sex. The therapist potentially has many roles. The therapist may educate the parents about sexual health, provide the parents with literature, and role play with parents a conversation about sex to have with their adolescent. As therapists continue to work with families, whether it is through family therapy, individual with the parent, or individual with the adolescent, it is important that they, as the trained professional, assist parents in talking with their adolescent about sex. Finally, as scholars and practitioners, it is important for our work to inform the research and the research to inform our work (Goodheart, 2006). There are numerous studies about parent-child communication regarding sexuality, various sex education programs, and therapists working with clients who are ethnically different. There are even a few articles about therapist sexual values and their training in human sexuality. However, there are not any articles that examine a therapist's cultural empathy, sexual values, and training and those factors may or may not contribute to how comfortable a therapist is discussing adolescent sexuality.

### *The Statement of the Problem*

This study is seeking to ask what effect does: (a) a therapist's level cultural empathy have on whether or not the therapist will facilitate a discussion about sex with an adolescent client and their parent(s); (b) a therapist's level of training in human sexuality or sex education have on whether or not the therapist will facilitate a discussion about sex with an adolescent client and their parent(s); and (c) a therapist's personal sexual values have on their willingness to facilitate a discussion about sex with an adolescent client and their parent(s).

### *General Hypotheses*

The researcher hypothesized that (a) the higher the therapist's level of cultural empathy the more likely the therapist will be to facilitate a discussion about sex with an adolescent client and their parent(s); (b) the more a therapist adheres to traditional sexual values the less willing they are to facilitate a discussion about sex with an adolescent client and their parent(s); and (c) the therapist's level of training will not be a factor in whether or not the therapist will facilitate a discussion about sex with an adolescent client and their parent(s).

### *The Delimitations (Scope of Study)*

The delimitations of this study are as follows:

1. It was delimited to mental health professionals.
2. It was delimited to therapists who self-reported working with clients age 19 and under.
3. It was delimited to sexuality solely in terms of heterosexual intercourse.

### *Definitions and Operational Terms*

The most frequently used terms in this text are defined as follows:

1. Facilitation of discussion about sex/sexuality: providing structure, support and guidance while parent(s) talk to their adolescent about sex.
2. Adolescent/teen: a young person between the ages of 13 and 19.
3. Heterosexual sexual intercourse: the penetration from a penis into a vagina during sexual activity.
4. Sexual decision-making: the ability to initiate wanted sexual activity, refuse unwanted sexual activity, and protect oneself from unwanted or unsafe sexual activity (Morokoff et al., 1997).

5. Sexuality: any sex-related issue
6. Therapist/ Mental health professional: a student, university faculty, or practitioner in counseling, psychology, marriage and family therapy, or social work.
7. Cultural empathy: refers to empathy in cross-cultural settings (Ridley & Lingle, 1996; Wang, et al, 2003).
8. Ethnocultural empathy: empathy directed toward people from racial and ethnic cultural groups who are different from one's own ethnocultural group. (Wang, et al. 2003).
9. Sexual Values: beliefs, opinions, and attitudes held by someone about sexuality.

## CHAPTER 2

### REVIEW OF LITERATURE

The purpose of this chapter is to present previous research that is relevant to the purpose of this study. It begins with a review of the research on various sex education programs and leads into a presentation of research on parents communicating with adolescents about sexuality and the relationship between sex education programs and parent communication. The review of the literature then moves into a description of professional considerations for the therapist who can help facilitate the process of parents communicating with their adolescents about sex.

#### *Sex Education and Parent Communication*

There are several sexuality education programs that are broadly used in education. These programs are: abstinence-only, safe-sex or disease prevention, and comprehensive. It should also be noted that none of the studies on the sexuality education programs focused on any specific racial/ethnic group. The following section will define each program and critically examine the literature on each program. It will be highlighted that the role of parents in these models is limited, with the exception of the comprehensive model.

The first sexuality education program that will be discussed is the abstinence-only approach. To be abstinent means that one would not engage in any type of sexual activity (Ott et al, 2010). Thus, as it relates to sexuality, abstinence would mean that one would not engage in fondling, vaginal sex, oral sex, or anal sex. In abstinence education programs, adolescents are taught that the only “safe and moral” (Daniluk & Towill, 2001, p.1028) way to approach

sexuality is to abstain. Abstinence programs employ a “just say ‘no’” approach and/ or saving one’s virginity for marriage. The goal of abstinence programs is to find ways to combat peer pressure and to express feelings and emotions in nonsexual ways (Kirby, et al, 1997). The abstinence model is the most widely used model public education (Daniluk & Towill, 2001), and is politically and financially supported by the federal government (Allegeier & Allegeier, 2000).

The limited research available indicates that abstinence programs are not effective in doing what they are designed to do. Daniluk and Towill (2001) report that in abstinence effectiveness studies there was a lack of effectiveness in reducing sexual activity, pregnancy, abortion and birthrates among the students who participated in the studies. In the studies evaluated by Allgeier and Allgeier, (2000), they found a lack of support of the effectiveness of abstinence programs. In fact, they found that some of the programs had the reverse effect and may have been the cause of teens engaging in sexual activity. Manlove, Papillio and Ikramullah (2004), found that there was no statistically significant difference in regards to when adolescents had their first sexual experience between the abstinence program participants and those in a control group.

Safe- sex or disease prevention programs are the second type of programs to be examined. The main focus of these programs is disease and pregnancy prevention. According to Daniluk and Towill (2001) anatomy and physiology are major components of this program in which teens are taught about reproduction, pregnancy, childbirth, and the prevention of STIs, including HIV/AIDS. In these programs adolescents receive knowledge and skills in how to handle peer pressure and pressure from their significant others; be consistent with safe practices, for those who are involved in sexual activities; and delaying sexual activity. The main emphasis

of the program is to reduce the risky sexual behaviors, such as not using condoms or other forms of contraception/birth control, in which teens may engage. Safe-sex programs also teach participants how to use the various forms of contraception, including condoms.

Research shows that safe-sex programs can be effective. In one program evaluation the adolescents who participated in the program were one and a half times more likely than the adolescents in the control group to report having used/using a condom or another method of birth control the last time that they had sexual intercourse (Manlove, Papillio & Ikramullah, 2004). Allgeier and Allgeier (2000) report that the safe-sex programs that they refer to as “postponement and protection programs” (p.289) have higher success rates than other sexuality education programs in decreasing the rates of pregnancy, delaying the loss of virginity, and increasing the use of methods of contraception among adolescents before they have actually become sexually active. Daniluk and Towill (2001) found that there is great variability in the actual course content in safe-sex programs and how they approach prevention, but overall these programs can not only delay the loss of virginity, but also decrease the number of partners teens have, decrease the amount risky sexual behavior, and how often they engage in sexual activity. This in turn leads to decreased rates of teen pregnancy and STIs, as well as increased awareness.

The third model is comprehensive sexuality education. Schools employ these programs in their health centers where teens can not only receive information about concerns they have relating to sexuality, but contraceptives and pregnancy tests as well (Maitlin, 2000).

Comprehensive sexuality education is defined as:

The primary goal of comprehensive sexuality education is to promote sexual health- to help young people develop a positive view of sexuality, to provide them with information

and skills to take care of their sexual health, and to help them acquire skills to make decisions both now and in the future (Rodriguez, 2000, p.67).

In addition Tolman, Striepe, and Harmon (2003) point out that psychological, spiritual, cultural, economic, physical, educational, and societal factors all have to be combined for the proper achievement of sexual health. A comprehensive sex education program in the school system should not only be in congruence with, but add to the sexual education that children will receive from other sources. Doing so would respect the diversity that resources such as family, those in the medical field, as well as those in faith and community groups can offer adolescents (Rodriguez, 2000). The guidelines published by the Sexuality Information and Education Council of the United States (SEICUS, 2004) state that anyone should be able to access sex education that through biological, psychological, socio-cultural, and spiritual components that teach teens communication, critical thinking and decision-making skills and also facilitates the exploration of attitudes, feelings and values that teens hold in regards to sexuality (National Guidelines Task Force, 2004). SEICUS originally published these guidelines known as *The Guidelines for Comprehensive Sexuality Education, Kindergarten-12<sup>th</sup> Grade* in 1991 and has made two revisions since then. These guidelines aim to provide children as well as adults with accurate health information. According to Daniluk and Towill (2001) the guidelines are premised on the idea that a part of being comprehensive means that sexuality education will not only be age and developmentally appropriate, but will incorporate sexual orientation, ethnicity, and culture into its curriculum in the hopes that teens who receive this type of sex education will feel comfortable in their various sexualities, make responsible decisions and their attitudes and behaviors will be healthy and positive.

There has been limited research into the effectiveness of comprehensive sexuality education programs. However, when focus groups were conducted with teen parents and examine the three major types of sexual education programs provided in schools: abstinence, safer-sex (sometimes called disease or pregnancy prevention), and comprehensive (teaching about sex from biological, psychological, and sociological perspectives), comprehensive sex education appears to be the best way to educate adolescents (Daniluk & Towill, 2001). The aforementioned authors found that studies conducted show significant decreases in pregnancy rates of the females who went through these programs. In addition, males abstained more often, and females reported more use of condoms than teens that did not participate in comprehensive programs.

An important part of a comprehensive program is parent involvement. Parents become involved with educating their adolescents about sexuality from birth. Whether parents recognize it or not, they are providing sexuality education when: they define how flexible or rigid the gender roles are in the home; the vocabulary chosen when discussing body parts, functions, and people; questions with sexual content are answered or ignored; parents display affection and tenderness or sexual and physical abuse; parents respond to the sexual content in songs, on television, movies, dance moves, and clothing; and children observe what parents wear and how they behave (Kaslow, 2006). When parents and adolescents communicate about sexuality, particularly mothers and daughter, it may help to reduce the at-risk behaviors adolescents sometimes engage in (Stiffler, et al., 2007). In a study by Miller and colleagues (2001) they noted that the adolescents most likely to delay first sexual experience, have fewer partners or to abstain for sexual intercourse were the adolescents who had open, positive and frequent



discussions about sexuality with their parents (Stiffler, et al., 2007). Studies have shown that parents who report having had discussions about sex with their adolescents are more comfortable with sexual matters and are more self-confident than parents who have not discussed sex with their adolescents (Pluhar, et al., 2007). These studies also report that the higher self-esteem a parent possesses the more likely the parent is to have frequent conversations about sexuality with their adolescent (Crawford et al., 1993, Pluhar et al., 2007). Also, discussions about sexuality with adolescents are more likely to happen when parents and adolescents can generally have “open and problem-free” discussions (Fisher, 1990; White, et al, 1995; Pluhar, 2007). Other studies have shown that the type of relationship parents have with their adolescents are also indicative of whether parents will be able to communicate with their adolescents about sex. Pluhar and colleagues report that in those studies parents who were stricter with their adolescents communicated about sex less frequently than parents who report having a close relationship with their adolescents. Also, part of being comfortable with communicating with an adolescent about sex would require the parents to see adolescents as “sexual subjects, and as having a right to experience the risks of sexuality” (Gilbert, 2007, p.48).

However, parents are often uncomfortable or uninformed about sex. Often parents know very little about sexual health or have been given misinformation by their own parents, education or the media. A number of parents admit that they have no idea where to find out about the most current information on sexual health. Finding the appropriate time and place, and fear of being able to state things clearly are also challenges that some parents face when trying to communicate with their adolescents about sexuality (Guilamo-Ramos, et al., 2006). Or if they know what to say, or have the information, parents have trouble bringing that knowledge into an

actual conversation with their adolescent (O'Donnell, et al., 2007). They admit that they are not comfortable talking with their teens about sex or particular aspects of sexuality. O'Donnell and colleagues (2007) found that parents often had a fear of losing control of the discussion and quoted one parents as saying:

I think it's something parents feel uncomfortable bringing up for the first time, partly because you don't want to know the answer, but also because you just don't know where it will lead. For instance, I might want to talk about dating, but what if it looks like it's going to lead into a 'birds and the bees' conversation (p.115).

In another study African-American mothers admitted that when communicating with their adolescents about sexuality they would provide the adolescent with factual information but declined to discuss the emotions often associated with sexual relationships, stating that if they were to discuss emotions about sex it may lead their adolescent to asking questions about the mother's emotions and experiences with sex- an area the mothers in this study were not comfortable discussing (Stiffler, et al., 2007). Overall, their lack of comfort may be a result of lack of knowledge, being unsure of what to say, and no role models to show them how to have conversations about sex.

Parental involvement is an important part of educating adolescents about sexuality. However, only one of the sexuality education programs includes parents. In abstinence-only programs adolescents are taught to abstain from sexual activity until marriage. This program is designed to teach adolescents to fight peer pressure and to express feelings and emotions in nonsexual ways but the limited research available indicates that these types of programs are not effective in delaying sexual activity until marriage. In safe-sex or disease prevention programs

the main emphasis is reducing risky sexual behaviors in which teens may engage by teaching adolescents about reproduction, pregnancy, childbirth, and the prevention of STIs. Research shows that safe-sex programs can increase awareness, delay the loss of virginity, decrease number of partners, decrease risky sexual behaviors, and decrease teen pregnancy and STI rates. However, there is variability in course content and how they approach prevention. In comprehensive sexuality programs adolescents are taught the biological, psychological, socio-cultural, and spiritual components as well as communication, critical thinking and decision-making skills which facilitates the exploration of attitudes, feelings and values that teens hold in regards to sexuality. This is done through incorporating and respecting the sexuality education that adolescents receive from resources such as parents and mental health professionals. Parents and adolescents communicate about sexuality from the day the teen is born and when continued into adolescence, communication may help to reduce the risky sexual behaviors adolescents sometimes engage in.

How can a therapist play a role in helping parents and adolescents communicate about sex? The following sections present literature to support ways in which the therapist can help facilitate sexuality discussions and these sections also present literature outlines characteristics a therapist should possess to effectively facilitate sexuality discussions between adolescents and their parent(s).

#### *Therapist's Role*

A part of comprehensive sex education is including resources such as mental health professionals (Rodriguez, 2000). Therapists have a great opportunity to facilitate sexuality communication between parents and adolescents that “addresses knowledge deficits, the role of

media, developmental considerations, and the impact of home, culture, and community on parent-child relationships and the inability to talk openly about sex.” (Aronowitz et al., 2006, p. 121). Surveys conducted by the Kaiser Foundation found that parents would welcome the help, encouragement, and support of healthcare providers and other community organizations in communicating with adolescents about sex because these parents report not feeling prepared (O’Donnell, et al., 2007). One role that a therapist may take in working with an adolescent or a family with an adolescent in it is educating parents and/or helping parents become more comfortable speaking with their adolescents about sex. The therapist may educate the parents about sexual health, provide the parents with literature, and role play with the parents a conversation about sex. In a study about HIV risk reduction by Villarruel and colleagues (2008) that focused on parent-adolescent communication, parents were provided information about communicating with their adolescents such as parental values and standards about sex, how to avoid risky situations, dealing with discomfort about communication, aspirations for their children, and creating opportunities for communication. Essentially the therapist’s role is to equip parents with information so that parents may serve as accurate resources for their adolescents (Delmonico & Griffin, 2008).

Another part of a comprehensive sex education for teens is educating them on the psychological aspects of engaging in sexual activity. This can be the role of the therapist. The therapist does not tell the teen what decision to make in regard to engaging in sexual activity. Rather, the therapist helps the adolescent understand the psychological impact of any decision they may make by providing sex education and responsible sexual values in an environment that adolescents feel safe to explore these issues (Ford & Hendrick, 2003). Part of that includes

taking a positive stance on sexuality education, which according to Giami and colleagues (2006) means not conveying the message that sex is not enjoyable, and not making the adolescents feel ashamed for their sexual feelings and responses. Further discussing the psychological impact means explaining to the teen possible feelings that may arise for themselves and their partner before, during and after a sexual activity; what those feelings may or may not indicate; how to communicate those feelings to a partner; and how to respond once a partner has communicated their feelings. The therapist may also teach the adolescent how to negotiate condom use or how to refuse sex (Shtarkshall, et al., 2007).

Ultimately, the therapist can, in addition to all of the aforementioned roles, serve as a good referral source. Later, the training of the therapist will be discussed but no amount of training the therapist may receive will equip them with the vast amounts of knowledge of other professionals. Therefore, a therapist will be well served to have a network of health educators, gynecologists, urologists, endocrinologists, obstetricians, pediatricians, bariatric physicians, pastors/spiritual advisors, yoga/meditation instructors, and massage therapists to whom they can refer parents and their adolescents for additional resources (Kaslow, 2006).

### *Therapist Training*

It is important that teens are being provided with the proper knowledge to make appropriate decisions. As mentioned before, parents are often misinformed themselves about sexuality. Therefore, it is the role of the therapist to be educated about sexuality and sexuality education. This education can come in the form of the therapist being informed about sexuality issues in the community, or from training received in their graduate program.

Research indicates that with the variety of information about sex that is easily available on the internet, therapists should be aware of what information is available to adolescents (Bleakley et al, 2009). Therefore, it would be important for therapists to have some knowledge of technology and the internet, and what information and misinformation is available online. This will help the therapist better formulate therapeutic questions for parents and adolescents and help facilitate clinically useful conversations (Delmonico & Griffin, 2008). In addition, being familiar with the information online helps the therapist experience first-hand some of the psychological factors associated with using the internet, some of the risky behaviors (e.g., watching pornography, and meeting people online), online addictions, level of secrecy and it helps the therapist communicate with the adolescent in a more “informed and genuine way” (Delmonico & Griffin, 2008, p.437).

Therapists should also be informed about the different models of sexuality education, including the ones in their local school district. As mentioned earlier there are three different types of sexuality education: abstinence-only, safe-sex or disease prevention, and comprehensive. There are differences within each program and knowing which one is used in the therapist’s local district can provide the therapist with an idea of what information the adolescent may have been given. In addition, therapists should also stay informed on the prevalence rates of teen sexuality. For example, the Youth Risk Behavior Surveillance Survey conducted in 2005 by the Centers for Disease Control and Prevention (CDC) found: 46.8% of 13,917 teens surveyed nationwide had had sexual intercourse; 33.9% were currently sexually active; and 14.3% had sexual intercourse with at least four people in their lifetime. Other statistics from 2003 show that while 1 in 5 teens reports having sex before the age of 15, almost half of the high school students

surveyed are experienced sexually and by the time these students graduate high school 6 out of 10 will have had sex (Manlove, Papillio & Ikramullah, 2004).

Perhaps one of the more important places in which therapists receive sexuality education is in their graduate training programs (Miller & Byers, 2009). A course in human sexuality and/or some training in the current sexual health information is essential for therapists to have taken before facilitating a discussion about sex with adolescents (Delmonico & Griffin, 2008). There have been a number of studies on the sexuality education/training of therapists (Miller & Byers, 2010; Miller & Byers, 2009; Ford & Hendrick, 2003; and Wiederman & Sansone, 1999). While, the typical therapist receives little in depth sexuality education/training during their tenure in graduate school and internship (Miller & Byers, 2009), they do receive some information on sexuality issues (Myers & Byers, 2010). In the Ford and Hendrick study (2003) the authors found that over 75% of respondents received training in sexuality issues. The Wiederman and Sansone (1999) study found that of the doctoral students, interns, doctoral faculty, and internship faculty surveyed, almost half of those surveyed reported that while it was rare to have an entire course on a specific sexuality topic, a number of sexuality topics were covered in the context of other courses. Miller and Byers (2010) surveyed 162 psychologists about their graduate school training in sexuality issues. The authors found that nearly all of the psychologists surveyed received some training related to sexuality (Miller & Byers, 2010).

One of the aspects of training that was only addressed in one of the previously mentioned studies was the sexual values held by the therapist. In working with clients, adolescents in particular, therapists should be aware of their own personal values to ensure that their values do not interfere with how they work with their clients. The following section will address this topic.

### *Therapist's Sexual Values*

In mental health, sexual values are not excluded from the values that therapists carry into the room (Ford and Hendrick, 2003). Therapists have opinions, thoughts and beliefs about premarital sex, consensual versus nonconsensual sex, incest and/or sexual abuse, extramarital sex, multiple sex partners, sex with members of the same gender, adolescent sex, and elderly sex. In one study, the authors found that sex within a monogamous marriage or, even if it was in later adulthood, was viewed more positively by therapists than premarital, infidelity, multiple partners or adolescent sex (Ford and Hendrick, 2003). The opinions and beliefs held by the therapist will differ based on gender, religion, and political affiliation (Ford and Hendrick, 2003).

After examining their own values therapists should also learn the cultural norms and values that underlie adolescents' sexual behavior and knowledge (Deardorff, Tschann & Flores, 2008). This may include understanding the contextual factors (religious, cultural) views of sexuality that a family may be influenced by. In particular the issue of how race and culture impact sexuality and sexuality education is a critical one. As the United States becomes more diverse it becomes important for therapists to be competent in their knowledge and awareness of the multicultural and gender norms, which includes stereotypes of sexuality (Comas-Diaz & Greene, 1994).

### *Therapist Cultural Empathy and Their Responses to Ethnically Different Clients*

There are a number of factors that a culturally empathic therapist will consider when talking with parents about how to communicate with their adolescents about sex. For example, Villarruel and colleagues (2008) noted that when working with some Mexican families it is important to consider factors such as the gender identity of the parent and adolescent,



familialism, and religiosity. The authors defined familialism as “strong identification with the family, attachment to the family, and feelings of loyalty, reciprocity, and solidarity with family members” (Villarruel et al., 2008, p.373) and religiosity as, “religious practice and belief, church attendance, and valuing religion”. (Guilamo-Ramos, et al., 2006, p.170).

It is also important for therapists to have a level of cultural empathy when relating to clients, particularly with African American and Latino adolescents, because there are few sex education programs that are “culturally relevant and developmentally appropriate” (O’Donnell, et al., 2007, p.108). Sue and colleagues (1992) note that therapists may be culturally oppressing their clients if the therapist is unaware of how the conditioning of themselves, their clients, and the sociopolitical systems of which each person is a part of impact the therapeutic relationship.

One way that awareness can be reached is by therapists being informed on the prevalence rates and statistics related to their clients presenting issues. For instance, if a therapist is working with adolescents or the adolescent’s parent(s) on sexuality issues, the therapist may want to know that according to the Guttmacher Institute in 2006 the pregnancy rate among women aged 15-19 increased by 3% for the first time in a decade to 71.5 pregnancies per every 1,000 women in that age group (2010) . It is important for the therapist to note however that those rates were higher among African-American and Latina women. Among African-American women aged 15–19, the nationwide pregnancy rate was 126.3 per 1,000 women in 2006 (Guttmacher, 2010). Then among Latina women aged 15-19, the nationwide pregnancy rate was 126.6 per 1,000 women in 2006 (Guttmacher, 2010). Additionally, the Guttmacher Institute (2009) found that African-Americans are the group most heavily affected by Chlamydia and gonorrhea and reported rates of both infections are 9–19 times higher among blacks than whites. Also, they

noted that the rates of Chlamydia among women aged 15-24 were five times as high as women overall (Guttmacher Institute, 2009). The awareness of those statistics and prevalence rates adhere to Nation and colleagues (2003) statement that a community's norms, cultural beliefs, and practices should be incorporated into the content, delivery and evaluation of any prevention program.

As defined earlier, cultural empathy occurs when a therapist displays empathy in a cross-cultural setting (Wang, et al, 2003; Ridley and Lingle, 1996). The therapist's ability to display cultural empathy is part of multicultural competence which has been defined as a therapist's knowledge, skills, attitudes and/or beliefs that impact the therapist's work with individuals from different cultural groups (Constantine, 2000; Arredondo et al., 1996; Sue, Arredondo & McDavis, 1992; Sue et al., 1982, 1998). More specifically and for use in this study, cultural empathy has been defined by Wang and colleagues (2003) as ethnocultural empathy. According to Wang and colleagues ethnoculturally empathy is the ability of an individual to display empathic feeling and expression, empathic perspective taking, acceptance of cultural differences, and empathic awareness toward people from racial and ethnic cultural groups who are different from one's own ethnocultural group.

For the ethnoculturally empathic therapist working with a client about sexual behavior it is important that the therapist be aware of societal stereotypes and their own biases related to ethnicity and sex. For example in her book, *Stolen Women: Reclaiming Our Sexuality, Taking Back Our Lives*, (1997) Gail Wyatt talks about the different stereotypes society has about African American women: the permissive one, the mammy, the she-devil, and the workhorse. Wyatt defines the permissive one as the woman who is sexually promiscuous and whom

everyone assumes is desirable because of her willingness and availability to engage in sexual activity. The mammy is characterized as the selfless caregiver who is overweight, darker-skinned and asexual. The she-devil is described as the woman with the most negative stereotypes. This woman has no remorse for the evil things she does such as: having sex anytime, anywhere; only after a man's money; and will bring a man down by taking him away from his family. Finally, the workhorse is labeled the strong woman who can tolerate all types of abuse, and she is educated, high-achieving, yet she is lonely with no children and does not desire sex. Wyatt also listed a number of stereotypes that she heard, read, or encountered over the years about African American women and their sexuality. Some of them are: sex is to have babies and not for enjoyment; some women should be virgins before marriage; some women have babies to receive financial support like welfare; some women are more promiscuous than others; and some women use sex to get what they want.

In their book, *Women of Color: Integrating Ethnic and Gender Identities in Psychotherapy*, Lillian Comas-Diaz and Beverly Greene discuss the stereotypes related specifically to Latina women. They describe two extreme categories of how Latina women are perceived in regards to their sexuality. They describe one extreme in which Latina women are considered “virginal” or “Madonna-like”. This type of woman is described as sexually naïve, chaste, martyrs, and sexually repressed. A woman like this is very similar to the Virgin Mary. On the opposite end of the spectrum the authors describe the “whores”. These women are considered to be promiscuous and sexually permissive. They are similar to the biblical Eve who was known to be a “self-serving temptress” (Comas-Diaz & Greene, p. 121).

In another example, Chitra Sankaran and Chng Huang Hoon (2004) discuss a common stereotype Asian women experience, aside from being known as the model minority. They note that Asian women are often perceived as all living in third world areas and coming from disadvantaged communities. In the book, *Asian American Psychology: Current Perspectives* (2008), Drs. Nita Tewari and Alvin Alvarez further discuss the stereotypes related to sexuality that Asian American women face. The authors note that during the time when America's military was at war with different countries in Asia, the women were characterized on two extremes. One was the dragon lady who had long fingernails, and was evil and sinister. The other extreme was the woman who was innocent, fragile and needed a man to rescue her. After the war, the geisha became popular and Asian women began to be viewed as exotic and perfect who knew exactly how to pleasure a man sexually (p. 198).

Native American women also face stereotypes about their sexuality. In the text, *The Readers' Companion to U.S. Women's History*, Barbara Mankiller describes the common stereotypes of Native American women. According to Mankiller these women were considered to be invisible except during the period of colonization when two stereotypes emerged. The first stereotype is the Pocahontas, who is considered to be trustworthy and loyal to her family and friends, yet useful for white men. The other is known as the squaw. This woman catered to men's sexual needs, and had babies.

Men of color in general have also experienced sexual typecasting. LeMoncheck in *Loose Women, Lecherous Men: A Feminist Philosophy of Sex* (1997), described some of those stereotypes. African American men have been characterized as oversexed with large penises.

Latinos were described as passionate Don Juans whose masculinity is defined by their sexual prowess. However, Asian men are considered to be sexually restrained.

There are also sexuality stereotypes based on sexual orientation, religion, age, and disability (Mankiller, 1998). As therapists become knowledgeable and aware of the racial and cultural sexuality stereotypes, they should respond to clients in a way that is culturally empathic.

#### *How this all intersects*

As therapists continue to work with families, whether it is through family therapy, individual therapy with the parent, or individual with the adolescent, it is important that they, as the trained professional, assist parents in talking with their adolescent about sex. However, in order for the therapist to provide a safe environment in which to facilitate this discussion there must be some therapeutic qualities already in place. A safe counseling environment is one in which the therapist provides a non-judgmental setting for the client to process what is going on in their life. This means that the therapist is aware of the stereotypes related to the client they are working with. They are also aware of how those stereotypes are impacting their client. Though the therapist is never totally free from judgment they should make their best effort to not let their values negatively impact their work with clients (Ford and Hendrick, 2003). In order to not let their values negatively impact their work with facilitating discussions about sex between parents and adolescents, the therapist should be aware of the ways in which adolescents are learning about sex and the therapists should possess cultural empathy and positive sexual values. By making themselves aware of the ways in which adolescents are learning about sex and possessing cultural empathy and positive sexual values, the therapist will be practicing multicultural competence, which is an important value held by the profession (Constantine,

2000). If counseling psychologists are going to contribute to the important values of the profession they should possess ethnocultural empathy and/or feel comfortable talking with parents and/or adolescents about sex. As scholars and practitioners, it is important for our work to inform the research and the research to inform our work (Goodheart, 2006). There are numerous studies about parent-child communication regarding sexuality, various sex education programs, and therapists working with clients who are ethnically different. There have also been various studies that focus on therapist's ethnocultural empathy (Wang, et al., 2003) but none that address how ethnocultural empathy impacts a therapist's ability to facilitate a discussion about sex between parents and adolescents. Many studies were found that provide valuable information on the experiences of sexuality in different populations and some of those studies included important information on how therapists could help but none of those studies address the role of ethnocultural empathy and sexual values in the role of the therapist. This study is seeking to examine how ethnocultural empathy and sexual values, along with therapist training may influence a therapist's comfort level with facilitating a discussion about sexuality between parents and adolescents.

## CHAPTER 3

### METHODOLOGY

#### *Sample*

A power analysis was conducted using an a priori sample size calculator for multiple regression (danielsoper.com). For analysis of variance and multiple regression, a medium effect size (.15), alpha level of .05, three predictors, and statistical power of .8 were entered as the parameters. To ensure statistical power at least 76 participants needed to complete the surveys.

#### *Descriptions of the Sample*

Participants were mental health professionals from across the United States. They were students and practicing clinicians in various mental health professions: counseling, clinical and counseling psychology, marriage and family therapy, and social workers. Participants were solicited from the following professional organizations: National Latina/o Psychological Association (NLPA), and the Association of Counseling Center Training Agencies (ACCTA). Participants were also solicited from mental health related training programs in the Southeast universities that offer their graduate students' practicum and/or internship opportunities at sites that serve adolescents age 19 and under.

#### Demographic Data

The final sample size was 81 participants. The survey was started by 119 individuals, 81 (68%) individuals completed the entire survey and thus were eligible for inclusion in the

statistical analysis. Participants ranged in age 24 to 63 years old, with a mean age of 33.99 (SD=8.50) (see Table 3.1 below). There were eight male participants and 73 female participants.

Table 3.1

***Age of Participants***

Age	N	Age	N	Age	N
24	6	36	2	54	3
25	3	37	4	58	1
26	3	38	1	63	1
27	4	39	1		
28	7	40	4		
29	6	41	1		
30	7	42	1		
31	5	43	2		
32	3	44	1		
33	3	46	3		
34	5	48	1		
35	3	52	1		

Participants identified themselves as African-American (14), Asian American (4), Hispanic/Latino/a (9), Caucasian/White (52), and Multiracial (2) (see Table 3.2 below).

Table 3.2

***Self-Reported Ethnic Status of Participants***

Ethnicity	Frequency	Percent
African American	14	17.3%
Asian American	4	4.9%
Hispanic/Latino	9	11.1%
White	52	64.2%
Multiracial	2	2.5%
Total	81	100%



Approximately half of the participants were enrolled in clinical or counseling psychology programs; a quarter were enrolled in counselor education programs; with the rest enrolled in social work, educational/school psychology programs; marriage and family therapy programs; and other programs. See table 3.3.

Table 3.3

***Professional Programs of participants***

Grad Program	Frequency (N)	Percent
Clinical/Counseling	39	48.1%
Counseling	21	25.9%
Social Work	12	14.8%
Educational/School	3	3.7%
Marriage & Family Therapy	4	4.9%
Other	2	2.5
Total	81	100%

Thirty-two participants (39.5%) earned or were in the process of earning philosophy doctorate (PhD). Twenty participants (24.7%) earned or were in the process of earning a master of arts/science (MA/MS). Twelve participants (14.8%) earned or were in the process of earning a master's of social work (MSW) and nine participants (11.1%) earned or were in the process of earning an education specialist (Ed. S) or master's of education (M. Ed.). Eight participants (9.9%) earned or were in the process of earning a doctorate in psychology (Psy.D.).

Table 3.4

***Degree of Participants***

Degree	Frequency (N)	Percent
Doctorate of Philosophy	32	39.5%
Masters of Arts/Science	20	24.7%
Master's of Social Work	12	14.8%
Education Specialist/Master's of Education	9	11.1%
Doctorate of Psychology	8	9.9%
Total	81	100%

***Instruments***

The instruments for this study were selected to assess demographics, cultural empathy, and sexual values. The following instruments were used in this study: (1) demographic questionnaire; (2) Scale of Ethnocultural Empathy (Wang, et al. 2003); and (3) Therapists' Sexual Values Scales (Ford & Hendrick, 2003).

**Demographic Questionnaire**

The researcher developed a 40-item demographic questionnaire. The questionnaire ascertained: age, gender, race, religious affiliation, level of training/education, and professional service area of the participants as well as demographic information about clients. Participants were also asked to provide information about their teen clients' source of sex education and rate how much the parents of their teens discuss topics such as sex, relationships, birth control, and so forth. Finally, participants were provided with a list of topics and asked to state where they thought adolescents learned about the topic. See Appendix C.

## **Scale of Ethnocultural Empathy**

The Scale of Ethnocultural Empathy (Wang, et al. 2003) is a 31-item scale that measures how empathetic the respondent will be towards people who are racially, ethnically or culturally different from themselves. Participants respond the items on a 6-point Likert scale: 1= strongly disagree to 6= strongly agree. There are four factors that comprise the total score: Empathetic Feeling and Expression, Empathetic Perspective-Taking, Acceptance of Cultural Difference, and Empathetic Awareness.

Validity and reliability for the SEE was assessed by the scale developers using a number of instruments in three different studies. The purpose of the first study was to insure that items accurately reflected the construct of ethnocultural empathy and to conduct exploratory factor analysis of those instruments (Wang, et al. 2003). In the first study participants were given a demographic questionnaire, the SEE, and the Balanced Inventory of Desired Responding (BIDR; Paulhus, 1984, 1991). The correlation analyses conducted found no significant correlation between the BIDR and the SEE total score ( $r = .08$ ) which provides evidence of discriminant validity for the SEE and its subscales (Wang, et. al. 2003). The purpose of the second study was to further assess validity. In addition to the instruments used in the first study, the developers added the Miville–Guzman Universality–Diversity Scale (M-GUDS; Miville et al., 1999) and the Davis Interpersonal Reactivity Index (IRI; Davis, 1983). Alpha coefficients were used to measure the internal consistency of the SEE total and the subscales. Acceptable levels of internal consistency were found as the SEE total and the subscales yielded alphas of .91, .89, .75, .73, and .76 (Wang, et. al., 2003). Analyses of the SEE and M-GUDS returned significant correlations between subscales and total scores indicating convergent validity for the SEE as a

measure of empathy (Wang, et. al., 2003). The third study was conducted by the scale developers to provide test-retest reliability. Participants in the third study were given the SEE and a demographic questionnaire and then retested two weeks later. The SEE and its subscales proved to be reliable over times as the reliability estimates were: SEE total ( $r = .76$ ), EFE ( $r = .76$ ), EP ( $r = .75$ ), AC ( $r = .86$ ), and EA ( $r = .64$ ) (Wang, et al., 2003).

To examine the internal consistency of the social empathy scale in this study, a reliability analysis was conducted on 31 items that assessed a therapist level of empathy when facilitating discussions about sex with an adolescent and their parents. The overall Cronbach's alpha for the SEE in this study was .593. The means for these items ranged from  $M = 1.26$  to  $5.48$  and standard deviations ranged from  $SD = .726$  to  $1.709$ .

#### Therapists' Sexual Values Questionnaire

The Therapists' Sexual Values Questionnaire (Ford & Hendrick, 2003) is 22-item questionnaire that asks therapists how comfortable they would feel about particular areas of sexuality. The first set of questions are related to general sexual values, while the second set of questions specifically asks therapists how comfortable they would be addressing certain issues of sexuality with their clients. These areas include sexual practices, sexual orientation, and age of sexually active people. Participants respond to the items on a 5-point scale from strongly agree to strongly disagree. This scale has no information on reliability or validity as it was initially developed as an information gathering tool by the researcher (Ford & Hendrick, 2003).

Item analyses were conducted on 22 items hypothesized to assess therapist sexual values when facilitating discussions about adolescent's sexual experiences in the presence of their

parents. The Cronbach's alpha obtained was .602. The means for these items ranged from  $M = 1.54$  to  $4.75$  and standard deviations ranged from  $SD = .516$  to  $5.698$ .

### **Case Vignette**

The researcher developed a case vignette. Initially the case vignette described a situation in which the therapist was confronted with having to make a decision regarding an adolescent who wants information about sex. Participants would then be given three options in terms of responding to the adolescent's request. The case vignette allowed the participant to demonstrate their use of cultural empathy and affirming sexual values. However, a research team comprised of some the researcher's doctoral classmates noted that because this is a quantitative study, the aforementioned design would not be easily measurable. They also noted that the options presented to participants may easily lead them to select the more socially desirable response. In addition, if details were given about the client such as race or gender that may influence responses, those influences were not being measured and that may have impacted the data. Based on that feedback the researcher developed a different case vignette. It was not based on a real case. Nor did it indicate any specific racial or gender characteristics. These design precautions were done to prevent answers based on social desirability or racial/gender prejudices/biases. The case vignette describes a situation in which the therapist is confronted with having to make a decision regarding an adolescent who wants information about sex. Using a 7-point scale participants are asked to rate their comfort level in working with an adolescent and their parent about sex. Using the same 7-point scale participants are asked to rate their comfort in working with someone who is ethnically different from them. Lastly, they are asked to write how they would respond to the situation.

## *Design*

The *Statistical Program for the Social Sciences*, version 16.0 (SPSS, Inc., 2007) was used to compute descriptive statistics among the variables in the model. To assess whether differences among mean scores existed between demographic variables within the independent and dependent variables, independent sample t-tests were used. Independent sample t-tests are used for comparing means of sub-groups (i.e., men versus women). This test is preferred over a paired sample t-test, which is used to compare the average of two values within individuals (i.e., pre and post scores) or an analysis of variance (ANOVA), which is used when there are three or more subgroups (i.e., White versus African American versus Latino).

To assess the relationship between the independent and dependent variables a bivariate Pearson correlation was used. This correlation test is used to measure how closely related two variables may be (SPSS, Inc., 2007).

## *Procedures*

### Recruitment of Participants

An email was sent to listserv administrators of the previously mentioned professional organizations and training programs. The email asked the listserv administrator to post to their listservs a message from the researcher asking for the recipients' participation in a study and a link to a webpage that included the informed consent and the survey.

### Data Collection

Once the participant received the email and selected the link they were first be directed to a page that includes the informed consent. If a participant selected "I Agree", they were directed to the next page that contained the case vignette, followed by the demographic questionnaire,

SEE and TSVS. Each survey was set to occur in that order. This order was intentionally selected to potentially reduce the amount of answers to the case vignette based on social desirability.

After completion of the survey the participant was directed to the last page that thanked them for completion in the study. A month after the initial email, a reminder email was sent to the listserv administrators and continued every two weeks until the desired sample number was reached.

### Data Analysis

Research Question 1: Are there differences between a therapist's level of cultural empathy and their level of comfort with facilitating a discussion between an adolescent and their parent(s) about sexuality?

Null Hypothesis: There will not be any statistically significant relationships between a therapist's level of cultural empathy as measured by the Scale of Ethnocultural Empathy (Wang, et. al. 2003) and their comfort in facilitating a discussion about sexuality between an adolescent and their parent(s) as measured by the case vignette.

Research Question 2: Are there differences between a therapist's sexual values and their level of comfort with facilitating a discussion between an adolescent and their parent(s) about sexuality?

Null Hypothesis: There will not be any statistically significant relationships between a therapist's sexual values as measured by the Therapists' Sexual Values Questionnaire (Ford and Hendrick, 2003) and their comfort in facilitating a discussion about sexuality between an adolescent and their parent(s) as measured by the case vignette.

Research Question 3: Are there differences between a therapist's training and their comfort with facilitating a discussion about sexuality between an adolescent and their parent(s)?

Null Hypothesis: There will not be any statistically significant relationships between a therapist's training as assessed by the demographic questionnaire and their level of comfort in facilitating a discussion about sexuality between an adolescent and their parent(s) as measured by the case vignette.

### *Limitations*

There are a number of limitations associated with the study based on the sample, instruments, and study procedures.

1. This study used participants from various mental health professions. These professionals completed surveys that asked them to assess themselves. Answers based on self perception allow for participants to respond based on social desirability (Regnerus & Uecker, 2007; Paulhus, 1984).
2. It may be that because the respondents are therapists they may recognize or assume the intent of the instruments and respond based on what the researcher was trying to assess (Constantine, 2000).
3. The order of the instruments was a limitation. The case vignette was presented first in an effort to prevent social desirability responses, there is no guarantee that some participants did not respond in that manner. Additionally it may have been possible for the order of the instruments to affect the outcome; that is, taking one instrument would impact the next instrument in a way that would not have happened if the instruments had been counterbalanced.
4. Having the survey available on the internet was also a limitation. An internet survey does not allow the researcher to insure informed consent, to explain instructions, to have



control over how participants understand the context of the data, nor conduct effective debriefings (Kraut, et al, 2004).

5. There was no psychometric information on two of the instruments and one of the instruments had low reliability. Therefore there may be threats to the validity of instruments. Psychometric properties of an instrument provide information on the reliability, validity, and generalizability that may affect the conclusions (Wilkinson, et al., 1999). The case vignette was developed by the researcher and was used for the first time in this study. Use of the Therapist's Sexual Values Questionnaire has only been documented by the original developers of the instrument. The Scale of Ethnocultural Empathy indicated acceptable levels of reliability when used by the instrument designers, however in this study the reliability was below an acceptable level.
6. Participation in the study was voluntary. Based on the information presented to prospective participants in the solicitation email, those respondents not comfortable with talking about sex may have chosen not to participate. This means that there was the potential for non-response bias or voluntary response bias. More specifically this means that those who chose not to respond may be very different in terms of sexual values and comfort in discussing sex, leaving room for an overrepresentation of participants that are comfortable talking about sex.

## CHAPTER 4

### RESULTS

This study examined the effect of a therapist's ethnocultural empathy, sexuality training, and sexual values on the level of comfort the therapist has about facilitating a discussion between adolescents and their parent(s) about sexuality. In this chapter the analysis of research questions and hypotheses are presented.

#### *Descriptive Statistics*

To assess whether differences among mean scores existed with some of the demographic variables (gender, race, and major) within the independent (facilitation comfort) and dependent variables (training, sex values and ethnocultural empathy), independent sample t-tests were used. Independent sample t-tests are used for comparing means of sub-groups.

More specifically, scores on facilitation comfort, training received, satisfaction with training, sex values, and ethnocultural empathy were examined based on gender. There were no significant results between any of the means. See table 4.1 for the results of the t-tests and table 4.2 for the means and standard deviations by gender.

Table 4.1

*Gender Independent Sample t-Test*

Variable	Mean Diff.	<i>p</i> -value	<i>t</i>	95% CI	
				Lower	Upper
Facilitation Comfort	-0.12	0.80	-0.25	-1.20	0.85
Training Received	0.19	0.30	1.05	-1.66	0.54
Training Satisfaction	0.26	0.53	0.63	-0.57	1.09
Sexual Values	1.30	0.24	-1.19	-3.47	0.87
Ethno. Empathy	-4.63	0.054	-1.96	-9.34	0.08

Table 4.2

*Gender Means and Standard Deviations*

Variable		Mean	Std. Dev.
Facilitation Comfort	Male	1.12	1.46
	Female	1.25	1.30
Training Received	Male	0.50	0.53
	Female	0.32	0.47
Training Satisfaction	Male	2.00	1.07
	Female	1.74	1.12
Sexual Values	Male	25.13	3.00
	Female	25.42	2.92
Ethno. Empathy	Male	58.88	8.90
	Female	63.51	6.05

Scores on facilitation comfort, training received, satisfaction with training, sex values, and ethnocultural empathy were examined based on major. There were no significant results among any of the means. See table 4.3 and 4.4 for results by major.

Table 4.3

*Major Independent Sample t-Test*

Variable	Mean Diff.	<i>p</i> -value	<i>t</i>	95% CI	
				Lower	Upper
Facilitation Comfort	-0.35	0.22	-1.23	-0.92	0.22
Training Received	-1.48	0.16	-1.42	-0.36	0.06
Training Satisfaction	-0.29	0.24	-1.18	-0.78	0.20
Sexual Values	-1.02	0.12	-1.57	-2.30	0.27
Ethno. Empathy	1.39	0.33	0.97	-1.45	4.23

Table 4.4

*Major Means and Standard Deviations*

Variable		Mean	Std. Dev.
Facilitation Comfort	Psychology	1.05	1.20
	Other	1.40	1.47
Training Received	Psychology	0.26	0.44
	Other	0.40	0.50
Training Satisfaction	Psychology	1.62	1.04
	Other	1.90	1.17
Sexual Values	Psychology	24.77	2.53
	Other	25.79	3.21
Ethno. Empathy	Psychology	63.77	5.71
	Other	62.38	7.20

Scores on facilitation comfort, training received, satisfaction with training, sex values, and ethnocultural empathy were examined based on self-reported race. There was a significant difference on the facilitation comfort scores based on race. The difference between the sample mean facilitation comfort in White participants and all other participants was 0.69 (SD= 1.44, 0.90), with a 95% confidence interval from .17 to 1.20; the *t* test statistic was 2.65, with 79 degrees of freedom and an associated *P* value of *p*= 0.01. No other *t*-test was significant. See tables 4.5 and 4.6.

Table 4.5

*Race Independent Sample t-Test*

Variable	Mean Diff.	<i>p</i> -value	<i>t</i>	95% CI	
				Lower	Upper
Facilitation Comfort	0.69	0.01	2.65*	0.17	1.20
Training Received	-0.02	0.87	-1.62	-0.24	0.20
Training Satisfaction	-.20	0.43	-0.79	-1.63	1.39
Sexual Values	-1.10	0.11	-1.63	-2.43	0.24
Ethno. Empathy	-2.07	0.17	-1.39	6.58	6.14

\* *p* = 0.01

Table 4.6

*Race Means and Standard Deviations*

Variable		Mean	Std. Dev.
Facilitation Comfort	White	1.48	1.44
	Other	0.79	0.90
Training Received	White	0.33	0.47
	Other	0.34	0.48
Training Satisfaction	White	1.69	1.06
	Other	1.90	1.21
Sexual Values	White	24.90	2.82
	Other	26.00	3.04
Ethno. Empathy	White	62.31	6.58
	Other	64.38	6.14

*Analysis of Research Questions and Hypotheses*

Research Question 1. Are there differences between a therapist's level of cultural empathy and their level of comfort with facilitating a discussion about sexuality between an adolescent and their parent(s)?

A bivariate Pearson correlation was conducted to evaluate the relationship between therapist's self-reported level of cultural empathy and their self-reported comfort level in

facilitating discussions between an adolescent and their parent(s) regarding sex and sexuality.

This correlation test is used to measure how closely related two variables may be or how linear is the relationship between the two variables. The independent variable was the therapist's level of comfort in facilitating sexual discussions with adolescent's and the adolescent's parents. The dependent variable was the aggregated sum for the level of cultural empathy as measured by the SEE.

There was a significant difference in mean scores on the independent variable based on race, thus the correlation test between therapist's self-reported level of cultural empathy and their self-reported comfort level in facilitating discussions between an adolescent and their parent(s) regarding sex and sexuality was separated into participants who self identified as White and all other participants. Among self-identified White participants there was a negative correlation between the variables  $r = -0.259$ ,  $n = 52$ ,  $p = 0.064$  (see Table 4.7 below). Among all other participants there was a negative correlation between the variables  $r = -0.321$ ,  $n = 29$ ,  $p = 0.90$  (see Table 4.8 below). The results of the bivariate Pearson correlation supported the hypothesis that there is no significant relationship between therapist's level of empathy and their comfort in facilitating a discussion between adolescent and their parent(s) about sexuality.

Table 4.7

*Pearson correlation matrix for White (n = 52) therapists*

	Training Received	Training Satisfaction	SVS	SEE
Facilitation	.399**	.539**	.278*	-.259
Comfort				
Training		.557**	.303*	-.184
Received				
Training			.252	-.420**
Satisfaction				
SVS				-.113

\*\*p < 0.01      \*p < 0.05

Table 4.8

*Pearson correlation matrix for other (n = 29) therapists*

	Training Received	Training Satisfaction	SVS	SEE
Facilitation	.251	.177	.378*	-.321
Comfort				
Training		.492**	-.049	-.298
Received				
Training			.322	-.158
Satisfaction				
SVS				-.077

\*\*p < 0.01      \*p < 0.05

Research Question 2. Are there differences between a therapist's sexual values and their level of comfort with facilitating a discussion about sexuality between an adolescent and their parent(s)?

A bivariate Pearson correlation was conducted to evaluate the relationship between therapist's self-reported sexual values and their self-reported comfort level in facilitating discussions between an adolescent and their parent(s) regarding sex and sexuality. This

correlation test is used to measure how closely related two variables may be or how linear is the relationship between the two variables. The independent variable was the therapist's level of comfort in facilitating sexual discussions with adolescent's and their parents. The dependent variable was the aggregated sum for the sexual values a therapist's possess. There was a significant difference in mean scores on the independent variable based on race, thus the correlation test between therapist's self-reported sexual values and their self-reported comfort level in facilitating discussions between an adolescent and their parent(s) regarding sex and sexuality was separated into participants who self identified as White and all other participants. Among self-identified White participants there was a positive correlation between the variables  $r = 0.278$ ,  $n=52$ ,  $p = 0.046$  (see Table 4.9 below). Among all other participants there was a positive correlation between the variables  $r = 0.378$ ,  $n=29$ ,  $p = 0.43$  (see Table 4.10 below). The results of the bivariate Pearson correlation did not support the hypothesis that there is no significant relationship between therapist's sexual values and their comfort in facilitating a discussion between adolescent and their parent(s) about sexuality.

Table 4.9

*Pearson correlation matrix for White (n=52) therapists*

	Training Received	Training Satisfaction	SVS	SEE
Facilitation				
Comfort	.399**	.539**	.278*	-.259
Training				
Received		.557**	.303*	-.184
Training				
Satisfaction			.252	-.420**
SVS				-.113

\*\*p < 0.01

\*p < 0.05



Table 4.10

*Pearson correlation matrix for other (n=29) therapists*

	Training Received	Training Satisfaction	SVS	SEE
Facilitation Comfort	.251	.177	.378*	-.321
Training Received		.492**	-.049	-.298
Training Satisfaction			.322	-.158
SVS				-.077

\*\*p < 0.01      \*p < 0.05

Research Question 3. Are there differences between a therapist's training and their comfort with facilitating a discussion about sexuality between an adolescent and their parent(s)?

A bivariate Pearson correlation was conducted to evaluate the relationship between therapist's training and their comfort in facilitating discussion about sexuality between an adolescent and their parent(s). This correlation test is used to measure how closely related two variables may be or how linear is the relationship between the two variables. The independent variable was the therapist's level of comfort in facilitating sexual discussions with adolescent's and their parents. The dependent variables were the level of training received regarding sexual issues and the feeling of adequate training received to prepare them to work on such issues.

There was a significant difference in mean scores on the independent variable based on race, thus the correlation test between therapist's self-reported sexual values and their self-reported comfort level in facilitating discussions between an adolescent and their parent(s) regarding sex and sexuality was separated into participants who self identified as White and all other participants.

Among self-identified White participants there was a positive correlation between the therapist's level of training received regarding sexual issues and level of comfort in facilitating sexual discussions with adolescent's and their parents  $r = 0.399$ ,  $n = 52$ ,  $p = 0.003$  (see Table 4.11 below). There was also a positive correlation between the feeling of adequate training received to prepare therapist to work on sexual issues and level of comfort in facilitating sexual discussions with adolescent's and their parents  $r = 0.539$ ,  $n = 52$ ,  $p = 0.000$  (see Table 4.11 below). Among all other participants there was a positive correlation between the therapist's level of training received regarding sexual issues and level of comfort in facilitating sexual discussions with adolescent's and their parents  $r = 0.251$ ,  $n = 29$ ,  $p = 0.188$  (see Table 4.12 below). There was also a positive correlation between the feeling of adequate training received to prepare therapist to work on sexual issues level and comfort in facilitating sexual discussions with adolescent's and their parents  $r = 0.177$ ,  $n = 52$ ,  $p = 0.359$  (see Table 4.12 below). The results of the bivariate Pearson correlation among White participants did not support the hypothesis that there is no significant relationship between therapist's training and their comfort in facilitating a discussion between adolescent and their parent(s) about sexuality. The results of the bivariate Pearson correlation among all other participants did support the hypothesis that there is no significant relationship between therapist's training and their comfort in facilitating a discussion between adolescent and their parent(s) about sexuality.

Table 4.11

*Pearson correlation matrix for White (52) therapists*

	Training Received	Training Satisfaction	SVS	SEE
Facilitation	.399**	.539**	.278*	-.259
Comfort				
Training		.557**	.303*	-.184
Received				
Training			.252	-.420**
Satisfaction				
SVS				-.113

\*\*p < 0.01      \*p < 0.05

Table 4.12

*Pearson correlation matrix for other (n=29) therapists*

	Training Received	Training Satisfaction	SVS	SEE
Facilitation	.251	.177	.378*	-.321
Comfort				
Training		.492**	-.049	-.298
Received				
Training			.322	-.158
Satisfaction				
SVS				-.077

\*\*p < 0.01      \*p < 0.05

## CHAPTER 5

### DISCUSSION

#### *Summary*

The purpose of this study was to examine the factors that have not been examined together in previous research that allow therapists to feel comfortable facilitating a discussion between adolescents and parents about sex. Previous research indicated that there are several sexuality education programs that are broadly used in education. Of the three major types of sexual education programs provided in schools: abstinence, safer-sex (sometimes called disease or pregnancy prevention), and comprehensive (teaching about sex from biological, psychological, and sociological perspectives), comprehensive sex education appears to be the best way to educate adolescents (Daniluk & Towill, 2001). An important part of a comprehensive sex education program is parent involvement. However, parents are often uncomfortable or uninformed about sex. Overall, their lack of comfort may be a result of lack of knowledge, being unsure of what to say, and no role models to show them how to have conversations about sex. Addressing this lack of comfort or information is where the therapist can be helpful. One role that a therapist may take, in working with an adolescent or a family with an adolescent in it is educating parents and/or helping parents become more comfortable speaking with their adolescents about sex. The therapist may educate the parents about sexual health, provide the parents with literature, and role play with the parents a conversation about sex. As mentioned before, parents are often misinformed themselves about sexuality. Therefore,

it is the role of the therapist to be educated about sexuality and sexuality education. This education can come in the form of the therapist being informed about sexuality issues in the community, or from training received in their graduate program. In addition to training, the therapist should provide a safe environment in which to facilitate this discussion and therefore there must be some therapeutic qualities already in place. A safe counseling environment is one in which the therapist provides a non-judgmental setting for the client to process what is going on in their life. This means that the therapist is aware of the stereotypes related to the client they are working with. They are also aware of how those stereotypes are impacting their client. Though the therapist is never totally free from judgment they should make their best effort to not let their values negatively impact their work with clients (Ford and Hendrick, 2003). In order to not let their values negatively impact their work with facilitating discussions about sex between parents and adolescents, the therapist should be aware of the ways in which adolescents are learning about sex and the therapists should possess cultural empathy and positive sexual values.

Previous research has not addressed these factors together. There have been studies that focused on therapist sexual values in working with clients across the lifespan (Ford & Hendrick, 2003) but none that address a therapist's sexual values when specifically working with adolescents. There have also been studies that focus on therapist's ethnocultural empathy (Wang et al., 2003) but none that address how ethnocultural empathy impacts a therapist's ability to facilitate a discussion about sex between parents and adolescents. This study sought to examine those factors together. More specifically this study examined whether a therapist's level of training, ethnocultural empathy and sexual values is correlated with the therapist's level of comfort with facilitating a discussion between adolescents and their parent(s) about sexuality.

This study sought to answer the following research questions:

- (1) will a therapist's level of cultural empathy have an effect on whether or not the therapist will facilitate a discussion about sex with an adolescent client and their parent(s)?;
- (2) will a therapist's personal sexual values have an effect on their willingness to facilitate a discussion about sex with an adolescent client and their parent(s)?; and
- (3) will a therapist's level of training in human sexuality or sex education have an effect on whether or not the therapist will facilitate a discussion about sex with an adolescent client and their parent(s)?

### *Discussion*

The results from this study indicated that there was a significant difference in mean scores for level of comfort facilitating a discussion between parents and adolescents about sexuality between participants who identified as White and those from other racial groups. Variables were split between participants who identified as White and those who identified with the other racial groups. Results indicated that regardless of self-identified race, the relationship between a therapist's level of ethnocultural empathy and their comfort with facilitating a discussion between parents and adolescents about sexuality was not significant, though scores were in the expected direction. Results also indicated that regardless of self-identified race, the relationship between a therapist's sexual values and their comfort with facilitating a discussion between parents and adolescents about sexuality was significant. However, only among White participants was there a significant relationship between a therapist's training and their comfort with facilitating a discussion between parents and adolescents about sexuality. Among participants of other races, the relationship between a therapist's training and their comfort with

facilitating a discussion between parents and adolescents about sexuality was not significant but scores were in the expected direction. Possible explanations for the non-significant, as well as the significant relationships are explained below.

Is there a relationship between a therapist's level of cultural empathy and their level of comfort with facilitating a discussion about sexuality between an adolescent and their parent(s)?

Though the results were not significant, the variables were in the expected direction. Results indicated that the higher a therapist's self-reported level of cultural empathy the more comfortable they would be in facilitating a discussion between an adolescent and their parent(s) about sexuality. This means that a therapist could have self-reported having a high level of ethnocultural empathy and then self-reported that they were at least "somewhat comfortable" facilitating a discussion between an adolescent and their parent(s) about sexuality.

A possible explanation is order effects. The first question that respondents were presented with was "How comfortable would you feel facilitating a discussion between parent(s) and adolescents about sexuality?" This question came after the informed consent that explained that the survey was about mental health professionals who work with adolescents and may have talked about sex with their clients. The respondents are therapists and they may have recognized or assumed the intent of the first question and responded based on what the researcher was trying to assess (Constantine, 2000).

Social desirability based on the nature of the profession, the nature of the question, and order effects is another possible explanation. Psychology ethical principles state that therapists are aware of their responsibilities and seek to benefit those with whom they work (APA, 2002). Based on the understanding of ethical principles and possibly assuming the intent of the first

question assessing hypothetical level of comfort, some therapists may have chosen the socially desirable answer.

“Social desirability bias is the tendency of individuals to want to make themselves appear better than they actually are. Social desirability comes in at least two forms: (1) self-deception, or the unconscious tendency to give inaccurate but honestly held descriptions of oneself and one's behavior, and (2) other-deception, or the active tendency to give more favorable self-descriptions to a researcher (Paulhus, 1984). Related to these, survey respondents may find themselves embarrassed when asked questions that are particularly sensitive, and may choose to lie to the interviewer rather than admit an action. Or they may "retract" behaviors: a respondent could say that "yes, that is true" of them at one point in time and "no, it's not true" at a later point in time. This may especially affect sensitive self-reports like those concerning sexual experience.” (Regnerus & Uereck, 2007).

In this study it is possible that because of the sensitive nature of the questions one or both of the aforementioned forms of social desirability occurred as participants were responding to a hypothetical situation.

Another possible explanation is comfort in online anonymity based on order effects. Meaning, therapists felt more comfortable with the anonymity of the online survey by the time they got to the ethnocultural empathy scale and were honest with their answers. Kraut and colleagues (2004) note that when participants are anonymous they are more likely to feel less accountable for their responses.



It is also possible that when working with clients, participants try provide a non-judgmental setting for the client to process what is going on in their life. This means that the therapist is aware of the stereotypes related to the client they are working with. They are also aware of how those stereotypes are impacting their client. Though the therapist is never totally free from judgment they should make their best effort to not let their values negatively impact their work with clients (Ford and Hendrick, 2003).

Are there differences between a therapist's sexual values and their level of comfort with facilitating a discussion about sexuality between an adolescent and their parent(s)? Results indicated a significant relationship between a therapist's sexual values and their level of comfort with facilitating a discussion about sexuality between an adolescent and their parent(s). Meaning, the more liberal a respondent's scores on the Therapist's Sexual Values Scale, they self-reported more comfort with facilitating a discussion between an adolescent and their parent(s) about sexuality.

One possible explanation is the same explanation for the lack of relationship between therapist's cultural empathy and comfort facilitating a sexuality discussion between an adolescent and their parent(s). That is the possible presence of order effects. The first question that respondents were presented with was "How comfortable would you feel facilitating a discussion between parent(s) and adolescents about sexuality?" This question came after the informed consent that explained that the survey was about mental health professionals who work with adolescents and may have talked about sex with their clients. The respondents are therapists and they may have recognized or assumed the intent of the first question and responded based on what the researcher was trying to assess (Constantine, 2000).

Another possible explanation for the statistical significance is nonresponse bias or self-selection. After 119 respondents electronically agreed to the informed consent and began the study, only 92 of the 119 respondents answered the first question of the survey which asked participants to rate how comfortable they would feel discussing sexuality with an adolescent and/or their parent(s). It could be assumed that the 27 respondents who dropped out without responding to the first question are not comfortable discussing sexuality. Then 10 more participants dropped out prior to completing the Therapist's Sexual Values Scale. This means that those who chose not to respond may be very different in terms of sexual values and comfort in discussing sex, leaving room for an overrepresentation of participants that are comfortable talking about sex.

Are there differences between a therapist's training and their comfort with facilitating a discussion about sexuality between an adolescent and their parent(s)? Results indicated that if a self-identified White received training and were satisfied with that training, the more likely that therapist will feel comfortable with facilitating a discussion about sexuality between an adolescent and their parent. The results among other therapists, though not significant, still yielded a positive relationship.

One reason the results were significant among White therapists and indicative of a positive relationship among other therapists was because the questions were encompassing of various amounts of training. The exact question was "Did you receive training (i.e. classes, workshops, direct supervision) regarding sexual issues?" Therefore, a participant who received any level of training of sexuality may have felt comfortable facilitating a hypothetical discussion about sexuality between an adolescent and their parent(s). Also, forty-four percent of participants

either “agreed” or “strongly agreed” that their training adequately prepared them to work with sexual related issues.

These findings are supported by the literature on therapist training. Delmonico and Griffin (2008) note that a course in human sexuality and/or some training in the current sexual health information is essential for therapists to have taken before facilitating a discussion about sex with adolescents. In the Ford and Hendrick study (2003) the authors found that over 75% of respondents received training in sexuality issues. The Wiederman and Sansone (1999) study found that of the doctoral students, interns, doctoral faculty, and internship faculty surveyed, almost half of those surveyed reported that while it was rare to have an entire course on a specific sexuality topic, a number of sexuality topics were covered in the context of other courses. Miller and Byers (2010) surveyed 162 psychologists about their graduate school training in sexuality issues. The authors found that nearly all of the psychologists surveyed received some training related to sexuality (Miller & Byers, 2010). Finally, Miller and Byers (2009) noted that clinicians who have had courses on sexual topics demonstrate greater knowledge and report increased feelings of professional competency specific to the topic area.

### *Limitations*

There were a few limitations associated with this study. One limitation of this study was the number of participants who started but did not complete the survey. Results indicated that 119 individuals began the study but 38 (32%) did not finish the survey. The reason for participant drop-out is unknown. Another limitation is related to the reported training of participants. The results of this study may have been limited by 77% of participants coming from counseling related programs. Most counseling programs do not mandate sexuality courses in

their curriculum (Miller & Byers, 2008). Therefore, there could be great variability in the quality of training the participants received and this study did not assess the quality of participants training. Conducting the survey online also may have presented some limitations. An internet survey does not allow the researcher to insure informed consent, to explain instructions, to have control over how participants understand the context of the data, nor conduct effective debriefings (Kraut, et al, 2004). Nonresponse bias or self-selection may have also been a limitation of this study. Participation in the study was voluntary. Based on the information in the solicitation email, potential participants could safely assume that there would be questions about sex. Only one participant stated that they were “very uncomfortable” facilitating a sexuality discussion and continued the survey. Therefore, those respondents not comfortable with talking about sex may have chosen not to continue participation. Another limitation was the lack of reliability from the SEE. An alpha level of .70 would be acceptable, however the Cronbach’s alpha from the SEE was .593. The reasons for this low reliability are unknown but perhaps with a larger sample and more ideal conditions, the reliability may have been higher.

#### *Considerations for future research*

Based on the results of this study and previous research, this researcher has outlined a few considerations for researchers. Future researchers may consider adding a social desirability scale that may allow for assessment of participants who may be responding based on what is socially desirable. Future researchers may find that doing a qualitative study may allow for individual responses and analysis of themes around those responses. Future researchers may find it beneficial to vary the order of the instruments. This may help researchers assess differences, if

any, in the responses from participants based on participants ability to predict the intent of the research. Varying the order of the instruments may also prevent order effects.

Future researchers may decide to randomly select therapists across the country to get a more representative sample of the therapist pool. Future researchers may try to prevent response/nonresponse bias. For example, future researchers may choose to conduct in person surveys, restricting sampling to a particular population, or varying the style of question (i.e., item reversal) so participants take their time to really read and respond to the questions (Tuckman, 1999). Future researchers may also choose to limit participation to one subset of therapists (i.e., counseling psychologists or social workers or marriage and family therapists).

Future researchers may want to further investigate the psychometric properties of the instruments. This is a newer area of research with a limited number of instruments and thus, it is important to not automatically assume that the current instruments are sound because the future use of these instruments can have an impact on the research (Wilkinson, et al., 1999). More specifically, Wilkinson and the Task Force on Statistical Inference (1999) note that when instruments are used in studies that are published, future researchers hesitate to change the instrument and if there are psychometric problems they go undetected. Undetected psychometric problems with instruments cause unreliable or invalid measures that skew the results of the research (Wilkinson, et al, 1999). Therefore, while it may have been appropriate to use these instruments in this study based on the reliability statistics of this data, future researchers should also assess the reliability of these instruments.

Future researchers may also want to more deeply assess the level of training and knowledge of therapists by using a scale such as the Sexual Intervention and Education Questionnaire by

Miller and Byers (2009). In this study participants were asked a couple of general questions about their training (e.g. “Did you receive training regarding sexual issues; and do you feel your training adequately prepared you to work with sexual issues”) and those questions produced significant results when compared with a therapist’s comfort in facilitating a discussion between adolescents and their parent(s) about sexuality. The Sexual Intervention and Education Questionnaire assesses the amount of training therapists received during their undergraduate and graduate educations in nine particular content areas such as STIs, sexual guilt and anxiety, and sexual orientation (Miller & Byers, 2008). By using the Sexual Intervention and Education Questionnaire future researchers could examine whether there are specific aspects of training that make a therapist more comfortable in facilitating a discussion between an adolescent and parent(s) about sexuality.

#### *Considerations for training and practice*

More standard training in sexuality (i.e., human development, reproduction, STIs, relationships, and sex education programs) could be beneficial in helping therapists become more confident in their abilities to help facilitate discussion between parents and adolescents about sexuality. Miller and Byers (2008) emphasize that training should include didactics, role-playing and modeling therapy sessions, sexuality assessment and interventions. Ford and Hendrick (2003) note that training should not only cover topics such as sexual orientation, sexual abuse, paraphilias, sexual dysfunction, and STIs but training should also focus on healthy sexuality and development across the lifespan.

More standard training should include how to talk with clients about sexuality, taking into consideration cultural factors. The aforementioned topics and aspects of training should also

provide information on specific cultural factors, such as religion, socioeconomic status, gender, and race/ethnicity and how those factors affect a client's sexuality. If graduate students are not receiving specific courses in sexuality education and the cultural factors related to sexuality then training on incorporating the cultural factors associated with discussions about sexuality can take place in multiculturalism courses, developmental psychology courses, therapy courses, professional ethics courses (Wiederman & Sansone, 1999). For instance, gender identity and sexual orientation could be a part of a multiculturalism class or, more specifically related to this study, a developmental psychology course could include information on the stereotypes associated with adolescent sexuality within particular ethnicities.

More standard training that allows therapists to assess their own awareness of their sexual values could be helpful. It is important for therapists to be aware of what they are bringing into the room, particularly with the often perceived sensitivity of discussing sex, and how those values may impact their work with clients.

More standard training should be offered in the form of continuing education for therapists that do not specialize in sex therapy (Miller & Byers, 2009). These authors note that there are numerous workshops, conferences, colloquia, etc. that are aimed at providing continuing education to sex therapists, but that these same trainings should be made available to non sex therapists. Specifically, therapists could benefit from workshops that allow role-playing and modeling client discussions about sexuality (Miller & Byers, 2008) or information on how to assess sexual history or discuss STIs with clients (Wiederman & Sansone, 1999).

More standard training that allow therapists to assess their own awareness of their level of ethnocultural empathy. As part of multicultural classes it may be helpful for therapists to in

addition to learning about various cultures but to also spend some time exploring their own biases that relate to the different cultures they are studying.

### *Conclusion*

The purpose of this study was to assess how a therapist's level of comfort in facilitating a discussion about sex between an adolescent and their parent(s) may be impacted by the therapist's training, their personal sexual values, and their level of ethnocultural empathy. Counseling psychologists value social justice, diversity and prevention (Reese & Vera, 2007). In 2003 Ivey and Collins stated that it was essential for counseling psychology to take on an upstream preventive approach, meaning that operating from a multicultural and social justice framework our profession should pay more attention to psychoeducation, community psychology, and prevention. Reese and Vera (2007) state that counseling psychology has an emphasis on prevention and combined with the field's expertise in multicultural competence, when working with psychologists and professionals from other specialties, there is the possibility to address the need of culturally relevant prevention programs. The therapist potentially has many roles. The therapist may educate the parents about sexual health, provide the parents with literature, and role play with parents a conversation about sex to have with their adolescent. As therapists continue to work with families, whether it is through family therapy, individual with the parent, or individual with the adolescent, it is important that they, as the trained professional, assist parents in talking with their adolescent about sex.



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## APPENDIX A

### **E-mail for Survey Participants**

Dear Mental Health Professional:

This e-mail is being sent to mental health professionals who have worked/or currently work with adolescent clients (19 years old and younger). I am writing to request your participation in completing a research survey to gather information about the educational and cultural experiences of professionals in the field of mental health who work with adolescents and have had at least one conversation about sex with a client. The data from this survey will be used to assess the nature of specific training and application in the area of adolescent sexuality in therapy and advocate for increased and improved training in order to provide psychological services in a culturally competent manner.

Completion of this survey will take about 20 minutes and participation is completely voluntary. Responses are confidential. This study has been approved by the University of Georgia Institutional Review Board (Project number: 2010-10433-0) and is under the supervision of Dr. Edward Delgado-Romero.

If you choose participate in this survey, please click on the link below to access the consent. After you read and agree to participation, you will be directed to start the survey. <http://www.surveymonkey.com/s/VP32DMT>

Thank you,

Dominique Broussard, M. Ed.

Counseling Psychology Doctoral Candidate

The University of Georgia

## APPENDIX B

### Online Informed Consent

Welcome to "Therapist Training, Cultural Empathy and Adolescent Sexuality," a web-based survey that examines the educational and cultural experiences of professionals in the field of mental health who work with adolescents (19 and younger) and have at one point had a conversation about sex. While there are no direct benefits for participation in this research survey, the results of this survey will be used to assess the current nature of training as well as advocate for more specialized training to meet the specific needs and considerations when working with adolescent clients and attempting to implement culturally sensitive treatment and interventions. Before taking part in this study, please read the consent form below and click on the "I Agree" button at the bottom of the page if you understand the statements and freely consent to participate in the study.

#### Consent Form

This research study involves a web-based survey designed to understand the cultural and educational experiences of professionals in the field of mental health who work with adolescent clients. The study is being conducted by Dominique Broussard, M.Ed., and is supervised by Dr. Edward Delgado-Romero of the University of Georgia. No deception is involved, and the study involves no known risk.

Participation in the study typically takes 20 minutes and is strictly confidential. In no case will responses from individual participants be identified. Rather, all data will be pooled and published in aggregate form only. Please note that Internet communications are insecure and there is a limit to the confidentiality that can be guaranteed due to the technology itself. If you are not comfortable with the level of confidentiality provided by the Internet, please feel free to copy the text and print out a copy of the survey, fill it out by hand, and mail it to me at the address given below, with no return address on the envelope.

While many individuals find participation in this study important and a valuable way to contribute to the field of psychological work with adolescents, some may find the questions about sex uncomfortable. Participation is voluntary, refusal to take part in the study involves no penalty, and participants may withdraw from the study at any time without penalty or loss of benefits.

The investigator will answer any further questions about the research, now or during the course of the project. Participants may contact the principal investigator, Dominique Broussard at [dabrouss@uga.edu](mailto:dabrouss@uga.edu); Professor Edward Delgado-Romero, Training Director of the Counseling Psychology program, Department of Counseling and Human Development Services, 402 Aderhold Hall, Athens, GA 30602, or at (706) 542-0500. Additional questions or problems regarding your rights as a research participant should be addressed to The Chairperson, Institutional Review Board, University of Georgia, 612 Boyd Graduate Studies Research Center, Athens, Georgia 30602-7411; Telephone (706) 542-3199; E-Mail Address [IRB@uga.edu](mailto:IRB@uga.edu).



## APPENDIX C

### Demographic Questionnaire

#### Demographics

Age:

Race:

Gender:

Religious Affiliation (If applicable):

1. Graduate Program Attended:

- a. Clinical/Counseling Psychology \_\_\_\_\_
- b. Counseling \_\_\_\_\_
- c. Educational/School Psychology \_\_\_\_\_
- d. Social Work \_\_\_\_\_
- e. Marriage and Family Therapy \_\_\_\_\_
- f. Human Development/Family Studies \_\_\_\_\_

2. Degree Program:

- a. MA/MS \_\_\_\_\_
- b. MSW \_\_\_\_\_
- c. PhD \_\_\_\_\_
- d. Psy.D. \_\_\_\_\_
- e. Ed.D. \_\_\_\_\_
- f. Other, specify \_\_\_\_\_

3. Theoretical Orientation (Mark the category that most closely represents your orientation):

- a. Behavioral \_\_\_\_\_
- b. Client-Centered \_\_\_\_\_
- c. Cognitive-Behavioral \_\_\_\_\_
- d. Existential \_\_\_\_\_
- e. Family Systems \_\_\_\_\_
- f. Humanistic \_\_\_\_\_
- g. Interpersonal \_\_\_\_\_
- h. Psychoanalytic/Psychodynamic \_\_\_\_\_
- i. Other, specify \_\_\_\_\_

4. What Type of Therapy do you Predominantly Practice (Mark up to two):

- a. Individual Adult Therapy \_\_\_\_\_
- b. Individual Adolescent Therapy \_\_\_\_\_
- c. Individual Child Therapy \_\_\_\_\_

- d. Couple/Marital Counseling \_\_\_\_\_
- e. Sex Therapy \_\_\_\_\_
- f. Family Therapy \_\_\_\_\_
- g. Group Therapy \_\_\_\_\_
- h. Other, specify \_\_\_\_\_

5. How often do you initiate discussion of sexual issues with your clients?

- a. Routinely \_\_\_\_\_
- b. Often \_\_\_\_\_
- c. Sometimes, as relevant \_\_\_\_\_
- d. Rarely \_\_\_\_\_
- e. Never, I wait for the client to bring up sexual issues \_\_\_\_\_

6. Did you receive training regarding sexual issues?

- a. Yes \_\_\_\_\_
- b. No \_\_\_\_\_

8. Do you feel your training adequately prepared you to work with sexual issues?

- a. Strongly Agree
- b. Agree
- c. Neutral
- d. Disagree
- e. Strongly Disagree

9. What is the Annual Income of most of the families you serve (circle one):

\$0 - \$20,000    \$20,001 - \$40,000    \$40,001 - \$60,000    more than \$60,000

**On average:**

10. Who do your teen parents live with?

Family    Partner's Family    Partner    Friends    Resident Hall    Other \_\_\_\_\_

**Please give your opinion on the following statements by rating them on the scale below.**

1= strongly agree; 2= agree; 3= neutral; 4= disagree; 5= strongly disagree; NA= not applicable

Parents talk to their teens about sex at least once every six months

1      2      3      4      5

Teens have adequate information to make decisions regarding sex

1      2      3      4      5

Parents are comfortable with teens asking them questions they really want to know about sex

1      2      3      4      5

Parents want to know the questions their teens have about sex

1      2      3      4      5

Parents talk with their teens about Sexually Transmitted Infections (STIs)

1      2      3      4      5

Parents talk with their teens about birth control

1      2      3      4      5

Parents talk with their teens about reproduction

1      2      3      4      5

Parents talk with their teens about condoms

1      2      3      4      5

Parents talk with their teens about choosing partners

1      2      3      4      5

Parents talk with their teens about romantic relationships

1      2      3      4      5

Parents talk with their teens about physical and sexual development

1      2      3      4      5

Parents talk with their teens about handling pressure to have sex

1      2      3      4      5

**Please rate how much you believe teens know about the following:**

1= everything; 2= a lot; 3= some things; 4= very little; 5= nothing

Sexually Transmitted Infections

1      2      3      4      5

Birth Control

1      2      3      4      5

Reproduction

1      2      3      4      5

Condoms

1      2      3      4      5

Choosing a Partner

1      2      3      4      5

Romantic Relationships

1      2      3      4      5

Physical and Sexual Development

1      2      3      4      5

Handling pressure to have sex

1      2      3      4      5

**Please indicate where you think adolescents get the following information**

Teens get information about Sexually Transmitted Infections (STIs) from:

Parents      Friends      Teachers      Boyfriend/Girlfriend (Partner)

Teens get information about birth control from:

Parents      Friends      Teachers      Boyfriend/Girlfriend (Partner)

Teens get information about reproduction from:

Parents      Friends      Teachers      Boyfriend/Girlfriend (Partner)

Teens get information about condoms from:

Parents      Friends      Teachers      Boyfriend/Girlfriend (Partner)

Teens get information about choosing partners from:

Parents      Friends      Teachers      Boyfriend/Girlfriend (Partner)

Teens get information about romantic relationships from:

Parents      Friends      Teachers      Boyfriend/Girlfriend (Partner)

Teens get information about physical and sexual development from:

Parents      Friends      Teachers      Boyfriend/Girlfriend (Partner)

Teens get information about handling pressure to have sex from:

Parents      Friends      Teachers      Boyfriend/Girlfriend (Partner)

## APPENDIX F

### Case Vignette

Imagine that you are a therapist and you have been working with an adolescent whose ethnicity is different from yours. You have seen this adolescent for five sessions and in the most recent session, they share that they are thinking about having sex. They want to discuss the situation with their parents but are not sure how their parents will react. Therefore, they want you to help them tell their parents.

- How comfortable are you discussing sex with the adolescent and their parents? (Please circle the answer you MOST identify with.)
  1. Very comfortable
  2. Comfortable
  3. Somewhat comfortable
  4. Neutral
  5. Somewhat uncomfortable
  6. Uncomfortable
  7. Very uncomfortable
- How comfortable are you working with someone who is ethnically different from you? (Please circle the answer you MOST identify with.)
  1. Very comfortable
  2. Comfortable
  3. Somewhat comfortable
  4. Neutral
  5. Somewhat uncomfortable
  6. Uncomfortable
  7. Very uncomfortable
- How would you respond in this situation? (use the space below to write your answer)