Factors Contributing to College Counselors’ Probability to Take A Client’s Sexual History

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ABSTRACT

FACTORS CONTRIBUTING TO COLLEGE COUNSELORS’ PROBABILITY TO TAKE A CLIENT’S SEXUAL HISTORY

Adam Gregory, Ph.D.
Department of Counseling and Higher Education
Northern Illinois University, 2022
Adam Carter and Peitao Zhu, Co-Directors

Many young adults are experiencing human sexuality-related issues and disorders. Researchers have found ample evidence linking hindered human sexuality discussions with clients by mental health professionals to low and reduced comfort, lack of willingness, and non-positive attitudes about sex. There is limited research that shows there is a connection between sex-based discussions in the field of mental health and the lack of clinicians’ education and training in the field of human sexuality. One of the most essential ways to identify, treat, and promote sexual health is a thorough sexual history taking by clinicians. Mental health professionals agree that taking a sexual history and knowing how to take a sexual history are important in the mental health field. With that, more than half of all counselors do not believe they take and have been trained to take a sexual history during an intake or initial counseling sessions. This study found human sexuality and education can increase college counseling professionals’ probability to take a sexual history from their clients. Comfort and willingness regarding human sexuality and sex-related topics also increased college counseling professionals’ probability to take a sexual history from their clients. Attitudes regarding human sexuality and sex-related topics was not found to be a predictor.
FACTORS CONTRIBUTING TO COLLEGE COUNSELORS’ PROBABILITY TO TAKE A CLIENT’S SEXUAL HISTORY

BY

ADAM GREGORY
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A DISSERTATION SUBMITTED TO THE GRADUATE SCHOOL IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE DOCTOR OF PHILOSOPHY

DEPARTMENT OF COUNSELING AND HIGHER EDUCATION

Doctoral Co-Directors:
Adam Carter, Ph.D., and Peitao Zhu, Ph.D.
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DEDICATION

I would like to dedicate this dissertation to my mother, Kim Flynn (aka, Mims).

I am aware that everything that I hold near and dear in this life, you gave to me.

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CHAPTER 1: INTRODUCTION

For decades, researchers have found ample evidence linking hindered human sexuality discussions with clients by mental health professionals to low and reduced comfort, lack of willingness, and non-positive attitudes about sex, all of which stem from the overall lack of human sexuality education and training of said clinicians (Anderson, 1986; Gregory & Paylo, 2020; Graham & Smith, 1984; Gray, House, & Eicken, 1996; Haboubi & Lincoln, 2003; Harris & Hays, 2008; McConnell, 1975). Research has also shown that individuals have a strong psychological connection between sexual health and well-being (Laumann, Paik, & Rosen, 1999; Tobkin, 2010; Wincze & Weisberg, 2015). It has been empirically proven that many patients and clients will not initiate communication regarding sexual matters with their healthcare providers believing that if sexual issues were important, then the clinician would initiate said communication; furthermore, clinicians believe if there was an issue or problem, patients or clients themselves would initiate said topic (Abramsohn, et al., 2013; Althof, Rosen, Perelman, & Rubio-Aurioles, 2013; Kingsberg, 2004; Lindau et al., 2012; Lindau et al., 2007; Marwick, 1999; Wimberly, Hogben, Moore-Ruffin, Moore, & Fry-Johnson, 2006). Patients and clients also avoid the topic of sex and sexual issues if they feel as though the clinician is not open or comfortable with said topics even if the clients feel it is relevant to their therapeutic goals (Hegarty, Brown, & Gunn, 2007; Metz & Seifert, 1990; Rubin, 2004).

Most research focused on sex-based discussions between healthcare seeker and healthcare provider has focused primarily within the medical field. There is less research that has
been completed on sex-based discussions in the field of mental health, but the limited research that does exist echoes that of discomfort and lack of training (Giami & Pacey, 2006; Gregory & Paylo, 2020; Mallicoat, 2014; Nasserzadeh, 2009; Southern & Cade, 2011). With that being said, early research in the field of mental health professionals has emphasized the importance of human sexuality education and comprehension, clinician components and training, and the important role that sexual awareness and attitudes play when said professionals are working with clients (Fyfe, 1980; Gray, Cummins, Johnson, & Mason, 1989; Gray, House, & Eicken, 1996; Kirkpatrick, 1980). More recent research has shown that mental health professionals who receive sexuality education and training report increased comfort and willingness to discuss sexual health-related topics with clients (Cupit, 2010; Flaget-Greener et al., 2015). Unfortunately, the majority of mental health clinicians do not receive sex or sexuality-related education or supervised clinical training (Gregory & Paylo, 2020; Reissing & Giulio, 2010).

Historically, sexual issues have been generally associated with the aging population (Laumann & Waite, 2008; Taylor & Gosney, 2011). More recent research has shown that nearly half of all the young women (48%) and nearly a fourth of the young men (23%) were living with a minimum of one sexual issue or concern (Moreau, Kagesten, & Blum, 2016). As of fall 2017, there were about 20.4 million students who attended colleges and universities in the United States (National Center for Education Statistics, n.d.), with most of the students, especially undergraduate students, being young adults (i.e., under the age of 25). Lockard, Hayes, Neff, and Locke (2014) found that the average age of a college student was 22.74 years and about 85% of participants were 25 years of age or younger. This makes college counseling centers ideal locations for researchers wanting to study the relationship between university and college mental
health providers’ human sexuality education and training and the comfort, willingness, and attitudes toward sex-based discussions with university and college-student clients.

**Study Rationale**

There is an importance and need for mental health clinicians working on college campuses to have sex-related discussions with clients, and it is likely that those discussions are lacking or hindered (Andrews, 2019; Giordano & Cashwell, 2018). As previously mentioned, researchers over several decades have found a variety of evidence linking the lack of and hindered sex with human sexuality discussions to low and reduced comfort, willingness, and attitudes. This stems from the overall lack of education and training of mental health clinicians regarding the topic of mental health’s connection to sex and human sexuality (Cupit, 2010; Flaget-Greener et al., 2015; Graham & Smith, 1984; Harris & Hays, 2008; Hartl et al., 2007; Hilton, 1997; Papaharitou et al., 2008; Reissing & Giulio, 2010; Zeglin, Van Dam & Hergenrather, 2018). Research has also shown that one of the most essential ways to identify, treat, and promote sexual health is a thorough sexual history taking by a clinician (Jones & Barton, 2004; Ribeiro et al., 2014). Furthermore, licensed counselors agree that taking a sexual history and knowing how to take a sexual history are important in the mental health field (Gregory & Palo, 2020). Finally, more than half of all counselors do not believe they take or have been trained to take a sexual history during an intake or initial counseling sessions (Gregory & Paylo, 2020).

**Statement of Problem**

Heretofore, no published materials have focused on sex and human sexuality-related communication as well as sexual history taking by mental health professionals employed by
universities and colleges working with college-student clients. This current research uses a descriptive, survey research design to obtain information on said topic.

**Purpose of Study**

This research explored the relationship between human sexuality education and training and the sexual history taking of mental health professionals working in college counseling centers. Specific variables included the aforementioned human sexuality education and training, as well as comfort levels, willingness, and attitudes of mental health professionals working in college counseling centers when communicating with clients about sex and human sexuality. Finally, this research also explored the relationship between all of the aforementioned variables and the probability of mental health professionals working in college counseling centers to take a sexual history from clients.

**Hypotheses and Research Questions**

This study intends to answer three major questions. The following questions are intended to partially fill the gap of research in the area of sex and human sexuality-related communication as well as sexual history taking by mental health professionals working within universities and colleges and while working with college-student clients. These include:

**Research Question 1:** What is the relationship between college counselors’ sexuality education and the probability they will take a client’s sexual history?

**Hₜ:** College counselors who report higher levels of human sexuality education and training will report a stronger probability to take a sexual history from clients.

**Research Question 2:** What is the relationship between college counselors’ comfort level, willingness, and attitudes regarding sex-based therapeutic conversations with clients and the probability they will take a client’s sexual history?
**H2:** College counselors who report higher comfort levels, willingness, and attitudes regarding sex-based therapeutic conversations with clients will report a stronger probability to take a client’s sexual history.

**Definition of Terms**

**Human Sexuality Education and Training**

“Sexuality education is more than the instruction of children and adolescents on anatomy and the physiology of biological sex and reproduction” (Breuner & Mattson, 2016, p. 1). Human sexuality education and training is defined as instruction provided to an individual that includes physical anatomy as well as the physiology of sex and reproduction, but also goes further in covering gender identity, sexual development, intimate relationships, affection, consent, sexual orientation, and more (Breuner & Mattson, 2016).

**College/University Counseling Center**

College counseling centers and university counseling centers provide mental health treatment as well as other services (e.g., outreach, care coordination, help with housing or food insecurities, campus trainings, etc.) within a college or university environment. College and university counseling centers typically offer a range of treatments including, but not limited to, individual counseling, group counseling, relationship counseling, and psychoeducation workshops (Xiao et al., 2017).

**Client**

A client is defined as an individual who is receiving services from a mental health professional. The term “client” is regularly used interchangeably with the term “patient.” For the purpose of this study, the clients are university and college students who are/were seeking
services from mental health professionals working within college and university counseling centers.

**Comfort**

For the purpose of this research study, comfort was specific to the degree to which one feels at ease engaging in sex-based communication with clients. Graham and Smith (1984) defined sexual comfort as “a broad, complex construct involving cognitive, affective, and behavioral responses to sexuality; as well as a developmental task influenced by the physiological, psychological, sociological, spiritual or religious, educational, and sexual aspects of one’s being” (p. 439).

**Willingness**

For the purpose of this research study, willingness is specific to the degree to which one feels prepared and ready to engage in sex-based communication with clients. Willingness to communicate is the level of interest an individual has to converse with one or more other individuals regarding a particular topic (MacIntyre, Dörnyei, Clément, & Noels, 1998).

**Attitude**

For the purpose of this research study, attitude is specific to the settled way one feels or thinks regarding the act of engaging in sex-based communication with clients. Attitudes are impressions and conceptions that individuals apply to societal objects or actions that have been formed due to values and ideals throughout a lifetime (Hitlin & Piliavin, 2004).

**Sexual History**

Sexual history taking is defined as a detailed and thorough number of open-ended questions that can be asked by a clinician covering an array of different sexual and sexuality-related topics (Tomlinson, 1998).
Mental Health Professional

A mental healthcare professional is defined as a healthcare clinician/service provider who offers services with the intent to improve an individual's mental health in addition to treating mental disorders (DeCou & Vidair, 2017). These professionals include but are not limited to psychologists, counselors, social workers, and therapists (e.g., marriage and family therapists) (Green, Xuan, Kwong, Holt, & Comer, 2016; Whitson, Bernard, & Kaufman, 2015).
CHAPTER 2: REVIEW OF LITERATURE

Introduction to Literature

Researchers have found that many mental health clinicians, including counselors, lack comfort, training, and willingness to take a thorough sexual history from clients (Gregory & Paylo, 2020; Harris & Hays, 2008; Miller & Byers, 2012). Furthermore, there are over a dozen sexual disorders and dysfunctions described in the Diagnostic and Statistical Manual of Mental Disorders, 5th ed. (DSM-5; American Psychiatric Association, 2013). The DSM-5 is used by virtually all mental health professionals and is the basis of training for nearly every properly trained and licensed professional working in the mental health field (Gayle & Raskin, 2017). Research also has shown that 52% of men and 63% of women receiving treatment from mental health professionals reported human sexuality-related concerns (McCarthy, Ginsberg, & Fucito, 2006). Finally, researchers have also shown an increase in individuals living with and suffering from sexual dysfunctions and other sexually related disorders across nearly every age group, but specifically in young adults (Capogrosso et al., 2013; Moreau, Kagesten, & Blum, 2016; Shaeer & Shaeer, 2012; Shifren, Monz, Russo, Segreti, & Johannes, 2008). Given that the majority of college students in the United States are considered young adults (i.e., under the age of 25), college counselors (i.e., mental health professionals working in college counseling centers) are the prime population for the proposed research (National Center for Education Statistics, 2018).

The purpose of this chapter and literature review is threefold. Within the first sections, I will illustrate the importance of sexual communication in the healthcare setting, specifically the
mental health setting, as well as discuss the current lack of sex and human sexuality-related communication in this setting. Second, I will describe the historic and current research regarding the variables of the current study (i.e., comfort, willingness, attitudes, and education of mental health clinicians regarding communication with clients about sex and human sexuality). The third and final sections offer a theoretical framework for which the research will be based (i.e., social learning theory), and how said theory may partially explain the lack of sex and human sexuality communication taking place between mental health clinicians and their clients.

**Sexual Health and Well-Being**

Individuals have a strong psychological connection between sexual health and well-being (Laumann, Paik, & Rosen, 1999; Tobkin, 2010; Wincze & Weisberg, 2015). The World Health Organization (2006a) defines sexual health as:

...a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. (p. 4)

Sexual disorders, dysfunctions, and poor sexual health have been associated with significant emotional distress, a negative body image, and distress with interpersonal relationships and can affect an individual’s overall health and well-being (Choi et al., 2014; Flynn et al., 2012; Jones & Barton, 2004; Mialon, Berchtold, Michaud, Gmel, & Suris, 2012; Seal, Bradford, & Meston, 2009; Wincze, & Weisberg, 2015). Furthermore, Downey and Friedman (2009) reported that clients who are living with sexual concerns are more prone to have issues that manifest in a number of negative ways that impact their overall psychological well-being. One of the most essential ways to identify, treat, and promote sexual health is through thorough sexual history
taking by clinicians (Jones & Barton, 2004; Ribeiro et al., 2014). Sexual history taking will be discussed more in-depth in a later section.

I would now like to clarify and address some of the language that is used in the following sections of this chapter. The next several paragraphs use the language printed within the particular studies (i.e., women, female, men, male). This is not to say there are only two genders or sexes. Gender is a spectrum. Sex is a biological and medical descriptor that is assigned in utero. The following information regarding women and men comes directly from empirical evidence, which utilized the terms “women/female” and “men/male.” This is not to say there is no gender or sex outside the two utilized terms. I would like to clarify that I recognize and appreciate all gender and sex identities. For the purpose of specificity and accuracy, the terms “women/female” and “men/male” will be used when reiterating the findings of other researchers. More information regarding this topic can be found later in this dissertation.

**Sexual Dysfunction Prevalence**

Researchers at the Cleveland Clinic (2020b) stated that sexual dysfunctions are becoming increasingly common and that “43% of women and 31% of men report some degree of difficulty” (p. 1) when it comes to their sexual functioning. Researchers working with the Global Online Sexuality Survey (Shaeer & Shaeer, 2012) reported similar findings, stating that 38% of men in America experience at least one sexual dysfunction. Researchers focused on women’s sexual distress found that more than 43% of women reported sexual problems, and more than 20% reported sexually-related personal distress (Shifren, Monz, Russo, Segreti, & Johannes, 2008). Furthermore, researchers with the Cleveland Clinic (2020b) stated that individuals living with or suffering from sexual dysfunctions are often hesitant to discuss them, therefore making voluntary discloser from clients for this diagnosis unlikely.
Typically, sexual dysfunctions are associated with the aging population (Laumann & Waite, 2008; Taylor & Gosney, 2011). More recently, researchers have shown that this notion is perhaps a falsity of the past. A recent study by Moreau, Kagesten, and Blum (2016) sampled 2,309 young men and women, ages ranging from 15-24 years old. Participants reported that nearly half of all the young women (48%) and nearly a fourth of the young men (23%) were living with a minimum of one sexual dysfunction. The most common reported sexual dysfunctions reported were what the DSM-5 lists as female arousal disorder and female orgasmic disorder. Another 21% of the young women surveyed reported different levels of pain during intercourse, often associated with genito-pelvic pain or penetration disorder according to the DSM-5. Nearly 10% of the young women also reported vaginal dryness on a regular basis, an issue that is almost always associated with aging women. The researchers of this study showed that there are a number of young women who are living with sexual dysfunctions despite these issues being typically associated with the aging population. Even though sexual dysfunction may not be the lone concern when it comes to mental health professionals taking sexual histories, for the purpose of this study, sexual dysfunctions and disorders will be the central argument.

Female Sexual Dysfunction

A number of researchers over the years have investigated the connection between women's sexual functioning and their body image (Erbil, 2013; Sanchez & Kiefer, 2007; Seal et al., 2009; Weaver & Byers, 2006; Yamamiya, Cash, & Thompson, 2006). Body image refers to an individual’s feelings about their body and appearance (Banfield & McCabe, 2002). The association between mental health issues related to negative body image has been around for decades (Myers & Rosen, 1999; Noles, Cash, & Winstead, 1985; Thompson & Stice, 2001; Voelker, Reel, & Greenleaf, 2015), with some researchers even connecting negative body image
to hindered self-esteem and depression (Gillen, 2015; Noles, Cash, & Winstead, 1985). More on the link between depression and sexual dysfunctions can be found in the following paragraph. In these studies, the authors have found that females with negative cognitive evaluations of body image report hindered sexual attitudes, sexual feelings, and sexual behaviors. Quinn-Nilas, Benson, Milhausen, Buchholz, and Goncalves (2016) went a step further, reporting that female body dissatisfaction was in fact predictive of the reduction of female sexual desire and arousal. The authors went on to describe how body dissatisfaction can lower sexual desire and could lead to avoidance of sexual activity. Finally, the authors wrote that because of this cognitive distraction, there is likely to be an increased sexual anxiety and lower sexual esteem in females who experience body dissatisfaction.

As previously mentioned, researchers have linked sexual issues to both men and women who suffer from and live with depression (Atlantis & Sullivan, 2012; Laurent & Simons, 2009; McCabe et al., 2016). Furthermore, researchers have also continually linked medications used to treat depression with sexual dysfunctions in both men and women (McCabe et al., 2016; Sramek, Murphy, & Cutler, 2016). Unfortunately, as stated by Kokras and Dalla (2017), “Women suffer from depression and anxiety disorders more often than men, and as a result they receive anti-depressants to a greater extent” (p. 731). This means that even though depression and depression medication are contributing factors for both men and women, women are more likely to have said issues relating to sexual dysfunctions. The prevalence of depression in college-age students can be found in a later section. There are also researchers who have been able to link sexual abuse, violence, and assault to sexual dysfunction as well as a number of other mental health-related issues (Finkelhor, Shattuck, Turner, & Hamby, 2014; Garneau-Fournier, McBain, Torres,
& Turchik, 2017; Race, Abuse, and Incest National Network [RAIN], 2018). These issues can pertain to any gender identity but are typically crimes committed more toward women.

Individuals going to colleges and universities are more likely to be sexually assaulted than the general population (Rape, Abuse & Incest National Network, 2018). Furthermore, Finkelhor et al. (2014) found that about one in four females have experienced some type of sexual abuse and/or sexual assault before the age of 18. Garneau-Fournier et al. (2017) surveyed 547 participants from a midsized midwestern university with more than 93% of participants reporting ages between 18 and 20. Within this study, researchers found that nearly 70% of the female participants reported at least one sexual dysfunction and 25% reported two or more sexual dysfunctions, with nearly half of the participants reporting lack of orgasm. Furthermore, more than 80% of survivors of sexual violence reported experiences with sexual dysfunction/s, and about 44% of participants living with sexual dysfunction/s reported sexual victimization. There is also a great deal of research involving young males experiencing sexual dysfunctions and disorders.

**Male Sexual Dysfunction**

Moreau, Kagesten, and Blum (2016) found that 23% of the male participants, ages ranging from 15 to 24 years, reported at least one sexual dysfunction, with nearly 10% reporting that it seriously hindered their sexual well-being. Some of the issues reported by these men included, but were not limited to, problems maintaining an erection, lack of sexual desire, and premature ejaculation. These results may be surprising, but new research is showing that young men are dealing with a number of sexual dysfunctions that typically were never attributed to healthy youth.
Erectile dysfunction (ED) is a common condition that has hindered the sexual function of males for decades (Glina, Sharlip, & Hellstom, 2013). Usually, the males suffering from this condition are forty years of age and older. There have been many causes for ED, including but not limited to cardiovascular health, medication side effects, and other medical conditions like obesity and diabetes (Laumann, Paik, & Rosen, 1999; Vlachopoulos, Terentes-Printzios, Ioakeimidis, Aznaouridis, & Stefanadis, 2013). Contrariwise, ED in younger men has been primarily ignored by medical research, being that ED in younger men rarely was caused by similar medical conditions (Ludwig & Phillips, 2014). It is also important to note that in the past, ED among young men was reported to affect as little as two percent of the population (Mialon, Berchtold, Michaud, Gmel, & Suris, 2012).

Recent research has shown that ED is affecting young men forty years of age and younger at an alarming increase than it did in previous decades. Up to 26% of young men (i.e., men 17 to 40 years of age) report signs and symptoms of erectile dysfunction (Capogrosso et al., 2013). According to Capogrosso et al. (2013), while the reason behind this phenomenon was usually a result of substance use or other medical conditions, it is now believed that many of these sufferers are experiencing ED due to excessive pornography usage. Excessive watching of visual sexual stimuli is the highest frequently reported behavioral problem among young men suffering from ED (Prause, Steele, Staley, Sabatinelli, & Hajcak, 2015) and is proving to be a definitive cause for this issue plaguing young men; the numbers are continuing to rise. While ED is rising at an alarming rate in young adult males, there is another more prevalent sexual dysfunction that has created issues for young males for decades.

Premature ejaculation is reportedly the most common sexual dysfunction in men, with research showing one in three men reporting this issue (Mayo Clinic, 2020). Another estimate
from the Cleveland Clinic (2020a) estimates that up to 40% of men experience premature ejaculation during their lifespan. While premature ejaculation can occur at any age, according to the DSM-5 (American Psychiatric Association, 2013), the most common age group affected are those who are 30 and under. Men suffering from this particular sexual dysfunction are also more likely to have comorbid mental health issues. In a recent study, researchers Yang, Lu, Song, Chen, & Liu (2019) found, “Among the 958 men evaluated, the prevalence of anxiety and depression in PE group was 82.07% (444/541) and 74.68% (404/541) respectively” (e13315). Because of this, as well as the emotional and mental stress that premature ejaculation can cause in a relationship, the Cleveland Clinic (2020a) stresses that men suffering from this sexual dysfunction seek treatment from mental health professionals. With some research showing that one-third of young men suffer from at least one sexual dysfunction (Mialon, Berchtold, Michaud, Gmel, & Suris, 2012) and nearly half of all the young women reporting a minimum of one sexual dysfunction (Moreau, Kagesten, & Blum, 2016), one can conclude that sexual issues and dysfunctions are no longer generalizable to the aging population.

**Non-Cisgender Sexual Dysfunctions**

“Gender nonconforming,” “agender,” “third sex,” “gender fluid,” and “nonbinary” are only a few of the terms used by individuals who identify as neither male nor female (Liszewski, Peebles, Yeung, & Arron, 2018). “Transgender” is the term used for individuals whose gender and/or sex identity is different from the sex that they were assigned in utero or at birth (Westbrook & Schilt, 2014). Liszewski, Peebles, Yeung, and Arron (2018) stated that many healthcare professionals may not be comfortable or know how to initiate communication with non-cisgender patients, much less understand their unique needs to care. Although the research is
scarce, research has shown that sexual dysfunctions and sexual issues are equally, if not more, prevalent among non-cisgender individuals.

Kerckhof et al. (2019) found that “the most frequent sexual dysfunctions experienced by trans women and trans men were difficulties initiating and seeking sexual contact (26% and 32%, respectively) and difficulties achieving an orgasm (29% and 15%, respectively)” (p. 2018). Non-cisgender individuals also often face hardships that prevent them from developing complete sexual health and well-being (Cerwenka et al., 2014). Non-cisgender, specifically transgender, individuals have been found to be at high risk of sexual abuse and sexual violence (Cense de Haas & Doorduin, 2017; Stotzer, 2009). Furthermore, as similarly found within gay and lesbian adults when it comes to internalized homophobia, non-cisgender individuals may have an internalized transphobia that can have a negative association in sexual function and satisfaction (Kerckhof et al., 2019; Kuyper & Vanwesenbeeck, 2011). There has also been reported decreases in sexual desire among transgender women after hormone therapy and gender-affirming surgery (Wierckx et al., 2014). Finally, all the aforementioned studies focused on the sexual issues and dysfunctions of non-cisgender individuals have found potential for and evidence of sexual difficulties within the non-cisgender umbrella community (Kerckhof et al., 2019).

**Health Professionals Discussing Sexual Matters**

Researchers have found that often patients and clients will not initiate communication regarding sexual matters with their healthcare professionals, believing that if it was important, the clinician would ask the client. Conversely clinicians also believe that if there was an issue or problem with the client or patient, that particular patient or client would initiate sex-related communication (Abramsohn et al., 2013; Althof, Rosen, Perelman, & Rubio-Aurioles, 2013;
Patients and clients also avoid the topic of sex and sexual issues if they feel as though the clinician is not open or comfortable with said topics even if the client feels it is relevant to their therapeutic goals (Hegarty, Brown, & Gunn, 2007; Metz & Seifert, 1990; Rubin, 2004). Blair et al. (2013) found that 70% of patients/clients believed that their health providers should be asking about sexual issues, and even expressed desire for said healthcare professionals to initiate communication regarding sexual concerns. Also, researchers have found that neglect and discomfort when gathering information about a patient’s sexual history are prevalent within the field of medicine (Ariffin et al., 2015; Bull et al., 1999; Burd, Nevadunsky, & Bachmann, 2006; Diamant, Schuster, McGuigan, & Lever, 1999; Esmail, Knox, & Scott, 2010; Loeb, Aagaard, Cali, & Lee, 2010; Loeb, Lee, Binswanger, Ellison, & Aagaard, 2011). Finally, researchers of a study pertaining to mental health clinicians found that more than half of the participants reported that they rarely or never questioned clients regarding sexual health and well-being (Reissing & Giulio, 2010).

**Mental Health Professionals Discussing Sexual Matters**

Most sexual discussion research has focused primarily within the medical field. There is less research that has been completed on said topic in the field of mental health, but the limited research that does exist echoes that of discomfort and lack of training (Giami & Pacey, 2006; Gregory & Paylo, 2020; Mallicoat, 2014; Nasserzadeh, 2009; Southern & Cade, 2011). Furthermore, Mallicoat (2014) found that in order for mental health professionals to gain valuable information on sexual dysfunctions and disorders, they would likely be required to seek postgraduate training. The lack of education and training will be discussed at length in a later
Similar research conducted by Giami and Pacey (2006) and Gill and Hough (2007) has also shown that because of personal discomfort, mental health clinicians are also fairly likely to avoid opportunities for and clinical training in a variety of sexual counseling opportunities.

Historically, diagnosis and treatment of patients and clients were the responsibilities of psychiatrists and psychologists who had earned a doctoral degree, medical or philosophical, respectively. Said custom has transformed significantly during the last 20 years with various master’s-level counselors now being responsible for diagnosis and treatment (Bogels, 1994; Jones, 2010; Mead, Hohenshil, & Singh, 1997). Because of this, counselor education programs have made adjustments, and the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2015) now mandates that licensed counselors obtain additional education to accommodate the changes. While the additional requirements mandated by CACREP have been beneficial for the counseling field, there remains a deficit in the needed training for specialized interviewing techniques (Jones, 2010; Turner, Hersen, & Heiser, 2003). Counselor education programs spend ample time and energy training future counselors and counselor educators in traditional interviewing techniques, but the importance on clinical interviewing may be lacking in some areas (Jones, 2010).

When working with new clients, the gathering of information has been deemed of the utmost importance for counselors. Novice counselors and counselors in training are taught to acquire information from their new clients including, but not limited to, medical history, mental health history, familial history, current and historical symptoms, social constructs, and substance use (Kavirayani & Maddirevula, 2014; MacKinnon, Michels, & Buckley, 2015; Schiller, 2009; Sommers-Flanagan & Heck, 2013; Sommers-Flanagan & Sommers-Flanagan, 2008; Waldinger & Jacobson, 2001). Novice counselors and counselors in training are taught by their educators,
supervisors, and workplace associates to assess for a variety of important and sensitive client information. More on this subject can be found in a later section covering social learning theory. Suicidal ideation, plan, and intent are frequently assessed, and a great deal of time and training is spent on making sure counselors are comfortable and competent when asking about these serious and sensitive subjects (Moerman, 2012; Reeves, Bowl, Wheeler, & Guthrie, 2004; Winter, Bradshaw, Bunn, & Wellsted, 2014). There is no question that the aforementioned training is important and the continuation of said practice needs to remain, but there is still important information for which mental health professionals are not training novice clinicians to gather. Despite the immense reasoning for mental health professionals to discuss sexually-related issues and complete a sexual history with clients, research has shown that most mental health professionals in fact do not regularly initiate professional sex-related conversations with clients or take thorough sexual histories (Gregory & Paylo, 2020; Miller & Byers, 2009; Reissing & Giulio, 2010).

**Sex, Human Sexuality, and Sexual History**

Sex and human sexuality, historically and still today, are still considered taboo topics in a variety of settings, both personal and professional (Baxter, & Wilmot, 1985; Evans, Avery, & Pederson, 1999; Morgan, Thorne, & Zurbiggen, 2010; Sewell, McGarity, & Strassberg, 2017). This is ironic given that the history of sex and human sexuality has been around for as long as human beings themselves, which is about 200,000 years (Antón & Swisher, 2004). By contrast, individuals have only been scientifically researching sex for about 150 years (Ellis, 1913), with the first being the six-volume *Studies in the Psychology of Sex*.

The term “sex” in research often refers to the biological classification of people as male, female, or other. Unfortunately, sex and gender are often listed as binary demographics despite
the research that shows that nearly one percent of young adults over the age of 18 in the United States identify their sex and/or gender outside of the binary terms (Herman, Flores, Brown, Wilson, & Conron, 2017). The American College Health Association (2017) reported in the Spring 2017 Reference Group Executive Summary that 2.4% of university and college students across the country identified as gender nonbinary. This is more than double of what the previous report averaged for young adults across the country who identify as gender nonbinary. This however is not what is meant by sex or sexual history in this proposal.

Sex, for the purpose of this study, refers to actions that incorporate genital, oral, anal, and vaginal stimulation (Turchik & Garske, 2009). According to the World Health Organization (2006b), human sexuality

is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles, relationships, and so on. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious, and spiritual factors. (p. 5)

Furthermore, sexuality is experienced intrapsychically through beliefs, thoughts, values, self-pleasure, fantasies, dialogue, education, media, and culture (Kleinplatz, 2012; Long, Burnett, & Thomas, 2006). Sex and sexuality are important facets of individuals’ lives and a major contributor to mental health and wellness for clients (Choi et al., 2014; Flynn et al., 2012; Jones, & Barton, 2004; Mialon, Berchtold, Michaud, Gmel, & Suris, 2012; Seal, Bradford, & Meston, 2009; Wincze & Weisberg, 2015). Sex issues and sexuality concerns account for roughly 30% of healthcare expenses in the United States (Elders, 2010). Because of this, one could argue that it is advantageous for mental healthcare professionals to have specialized education and training in human sexuality and mental health.
Sex and Sexuality in Mental Health

Sigmund Freud, a neurologist, is often recognized as the first scientist to identify the relationship between sex and healthy development (Freud, 1905/2017). Freud is considered by many to be the founding father of psychoanalysis (Nobus, 2013); therefore, one could argue that the connection between mental health and sex has been around since the start of psychoanalysis. Freud (1923/1961) even went as far as to argue that individuals develop through five psychosexual stages: oral, anal, phallic, latent, and genital. This is referred to as psychosexual development, and Freudian psychology suggests that from birth individuals possess a libido that is instinctual. Each of the previously mentioned stages are categorized by an erogenous zone and are the center of an individual’s libido. Freud believed that if youths were to be exposed to sexual frustration during any of these psychosexual developmental stages, the result would be long-term anxiety that eventually persists into neurosis as an adult (Freud, 1923/1961).

A few decades later, Alfred Kinsey became what we now refer to as a pioneer of sex research and the father of human sexuality research (Brown & Fee, 2003). Kinsey became interested in this research because he believed that sexual knowledge had never been researched scientifically or without bias (Kinsey et al., 1948/2003; Kinsey, Pomeroy, Martin, & Gebhard, 1953/1998). Over the course of many years, Kinsey was able to collect about 18,000 participants for his original research. Today, scientific research on sex and human sexuality is somewhat more common and spans numerous disciplines including, but not limited to, counseling, psychology, sociology, neurologic biology, and anthropology. Even though sex and human sexuality are becoming more typical research topics among academics across a variety of fields, these topics are not as commonly discussed within the general population or within a variety of healthcare fields (Abramsohn et al., 2013; Althof, Rosen, Perelman, & Rubio-Aurioles, 2013;
Kingsberg, 2004; Lindau et al., 2012; Lindau et al., 2007; Marwick, 1999; Wimberly, Hogben, Moore-Ruffin, Moore, & Fry-Johnson, 2006).

These early theorists paved the way for some of the more recent work on sexual knowledge and human sexuality. It was in the revolutionary work of Masters and Johnson (1966, 1970) that the modern interpretation of sex therapy and mental health work focused on sex-related issues was introduced (Leiblum, 2006; Wiederman, 1998). These modern frameworks considered the importance that sex and sexuality play when it comes to human physiology and behavior as well as broadened the understanding to which human sexuality affects one’s psychological functioning (Kaplan, 1974; Leiblum, 2006). Today’s mental health professionals should be competent with these issues and have the ability to conceptualize clients’ possible sexuality-related distress through various integrated theoretical frameworks (e.g., behavioral, biological, cognitive, psychodynamic; Zeglin, Van Dam, & Hergenrather, 2018).

Modern mental health professionals have access to a number of models that focus on human sexuality and the appropriate ways clinicians can address sexuality-related issues with which clients live. Dailey (1981) introduced the Circles of Sexuality with five fundamental parts: 1) intimacy, 2) sensuality, 3) sexual identity, 4) sexual health and reproduction, and 5) sexualization. It had been suggested that mental health practitioners be aware that human sexuality is multifaceted and has broad psychological effects (Kaplan, 1974); however, models like the Circles of Sexuality proposed that the five fundamental parts were innately interconnected, with each one having the ability to affect another (Zeglin & Mitchell, 2014), although, according to Zeglin and Mitchell (2014), the Circles of Sexuality does not thoroughly represent the complete social conceptualization of sexuality given that human sexuality is more vast and complex than previously imagined.
It was suggested by Zeglin, Van Dam, and Hergenrather (2018) that mental health professionals become familiar with the PLISSIT model (permission, limited information, specific suggestions, and intensive therapy (PLISSIT) when addressing sexuality-related issues with clients. The PLISSIT model, also referred to as the PLISSIT model of sex therapy, outlines a four-step approach that clinicians can use when addressing sexuality-related issues/distress (Annon, 1976). The first step of the model is permission (i.e., the clinician gives the client the permission to discuss topics related to and/or ask questions about sex and human sexuality). The second step is limited information (i.e., the clinician provides the client with appropriate evidence-based information). The third step is specific suggestions (i.e., the clinician and client work together to concretely discuss sexuality-related distress). The fourth and final step is intensive therapy (i.e., the clinician and client work together to discover and treat psychological etiologies). Davis and Taylor (2006) detailed these steps, giving special attention to the importance of the permission stage due to the fact that sex and human sexuality is a subject that is still considered taboo and prohibited even in health-related fields.

**Sex as a Topic of Discussion**

As previously mentioned throughout this dissertation, communicating about sex continues to be an uncomfortable and taboo topic (Davis & Taylor, 2006; Montemurro, Bartasavich, & Wintemute, 2015). According to Nuno (2017), in the United States, more than three-quarters of all young individuals (i.e., late teen years) have engaged in sexual intercourse, with more than two-thirds having had more than one sexual partner. Nuco (2017) went on to write that while most young adults are sexually active, “culturally it is felt that conversations about sex are best kept conservative” (p. 48) and furthermore believed that in order for individuals to find sexual health and well-being, developing a comfort with discourse about sex
is indispensable. Perhaps this discomfort and embarrassment discussing sex has been instilled in Americans from a very young age.

Despite the numerous progressions in science, comprehensive sex education in the United States remains prohibited by political, sociocultural, and conservative organizational groups that continue efforts to restrict the sex education of adolescents (Hall, Sales, Komro, & Santelli, 2016; Schalet et al., 2014). According to the Guttmacher Institute (2018), 37 states require that abstinence information be taught during sex education, with 26 of those states stressing abstinence during sexual education. This means more than half of the United States may not be communicating important sexual health information to adolescents during sex education. Unfortunately, the limitation in communication regarding sex does not stop with educational systems.

In 2012, Planned Parenthood released a national survey sampling more than 2,000 families regarding communication between parents and teens about sex. The survey revealed that less than 50% of all the parents surveyed reported feeling comfortable talking to their children about sex. Additionally, less than 18% of the teens who were surveyed reported feeling comfortable talking to their parents about sex. Furthermore, 42% of parents believed they talk to their children “many times” about sex, but with only 27% of teens agreeing. Leslie Kantor, Vice President of Education for Planned Parenthood Federation of America, is quoted in the article saying, “This survey shows that parents and teens have very different perceptions about how often they’re talking about sex and what’s being said during those talks” (p. 4). The same report showed that about a third of the teens surveyed reported that their parents had “never” or “only once” talked to them about sex (Planned Parenthood, 2012). It comes as no surprise that schools are not talking to their students about sex, but this survey goes a step further to show that many
children and adolescents in the United States are not being taught or even talked to about sex and human sexuality by the adults raising them.

Another study by Widman, Choukas-Bradley, Helms, Golin, & Prinstein (2014) asked school-based youths who they did communicate with about the topic of sex. The study found that more than half, 54%, of the participants reported not discussing any sexual topics with their dating partners. Furthermore, the study went on the reiterate that nearly one-third of the participants had never discussed sex with their parents and that one-fourth had never even discussed the topic of sex with their best friends (Widman et al., 2014). These studies strengthen the argument being made that young people across this country are being taught at young ages that sex is not a typical and welcoming topic for discussion. In a later section, social learning theory (SLT) will be discussed as an argument that from young ages individuals learn to believe sex is a taboo topic and therefore continue the lack of communication about it. Through the processes of attention, retention, reproduction, and motivation (Bandura, 1972), young people are being taught not to talk about sex. Unfortunately, the lack of communication about sex does not end with young adults and teens.

Researchers Montemurro, Bartasavich, and Wintermute (2015) acknowledge that over the recent years more attention has been given to human sexuality, but they also blatantly state that sex is still often considered an avoided and uncomfortable topic. They used a sample of adults, ages 20 to 68, to research gendered communication about human sexuality and sex. Researchers found that most of the participants reported discomfort when talking generally about sex and also reported a fear of judgment for discussing sexual behavior and even desire (Montemurro, Bartasavich, & Wintermute, 2015).
Sex as a Topic of Discussion with Mental Healthcare Providers

Farber and Hall (2002) surveyed 147 clients seeking psychotherapy services and found sexuality-related communication to be one of the most unlikely disclosed topics. This further shows that sex and sexuality is still considered to be a sensitive topic that holds a great deal of stigma in U.S. society (Davis & Taylor, 2006; Montemurro et al., 2015). Miller and Byers (2012) went on to state that mental health clinicians should be ready to approach the topic of sex with clients in a way similar to which they are able to approach other difficult topics of distress (e.g., suicidal ideation, abuse, substance use, and trauma). When sexually related topics are avoided, mental health clinicians may inadvertently perpetuate a “circle of silence” (Huffman, Hartenbach, Carter, Rash, & Kushner, 2015) and involuntarily reinforce the stigma related to sexuality.

In a study conducted by Reissing and Giulio (2010), researchers found that 60% of the 188 clinical psychologists surveyed did not ask or very infrequently asked clients about their health related to sexual topics. In a similar study, Miller and Byers (2012) reported that of the 110 clinical and/or counselling psychologists surveyed, only 40% of assessment and intake clients were directly asked about sexual concerns, and only 22% of clients being treated were asked about and/or treated for sexually related concerns. Given the results of said studies, as well as the similar findings reported in the review of literature, one can assume that many, if not most, mental healthcare providers are not likely to initiate sex as a topic of discussion with clients. There are many reasons as to why researchers believe or have found this to be true and will be discussed further later in this chapter.
Sexual History Taking

One of the most basic and introductory strategies to increase sexual communication between mental health professionals and clients would be clinicians taking a thorough sexual history from clients (Jones & Barton, 2004; Ribeiro et al., 2014). A detailed or thorough sexual history covers an array of different sexual and sexuality-related topics (Tomlinson, 1998). Topics should include, but are not limited to: relationship status, current and previous sexual partners, pregnancy, STDs, sexual frequency, masturbatory behaviors, sex drive, and physical or mental problems regarding sex as well as any anxiety, guilt, anger, and/or emotional or physical pain pertaining to any sexual function. Often open-ended questions and clinician silence can be utilized to get a more thorough and complete sexual history from patients and/or clients (Tomlinson, 1998). In addition, Tomlinson (1998) states that if a clinician’s attitude and approach to sexual topics are “matter of fact, then the patient will relax and become matter of fact, too” (p. 1573).

Althof, Rosen, Perelman, and Rubio-Aurioles (2013) wrote that the taking of a sexual history strengthens the therapeutic relationship, relays value and significance, and provides an empathetic and safe environment where hopefulness and change can grow. Furthermore, sexual communication including the taking of a sexual history can be seen from a moral and ethical perspective. The World Health Organization has stated that “all persons have the right to seek, receive and impart information related to sexuality, as well as receive the highest attainable standard of sexual health. This includes access to sexual and reproductive healthcare services” (2006b, p. 5). Because of this, mental health professionals should be incorporating sexual histories into their information gathering sessions with clients.
Comfort, Willingness, and Attitudes

Healthcare Providers’ Comfort with Sexuality

Harris and Hays (2008) wrote, “Most health professionals, regardless of discipline, lack sufficient preparation to be considered competent in addressing sexual concerns” (p. 240). Literature over the last several decades, including more recent research, continues to support this claim. As previously defined by Graham and Smith (1984), sexual comfort is “a broad, complex construct involving cognitive, affective, and behavioral responses to sexuality; as well as a developmental task influenced by the physiological, psychological, sociological, spiritual or religious, educational, and sexual aspects of one’s being” (p. 439). Graham and Smith (1984) went on to state that sex educators credited sexual attitudes and feelings, tolerance of others, and strong communication skills to be important aspects required for comfort with sexuality. This definition continues to be used as the demarcation of comfort with sexual topics among healthcare professionals.

Anderson (1986) introduced a developmental stage model of sexuality comfort in an attempt to accommodate the need for therapists in training to process their personal attitudes and beliefs about sex in order for them to become more comfortable with sexual-related topics that may be discussed with clients. Anderson’s (1986) research suggested individuals matriculate through four intersecting stages of comfort related to the types of sexual topics most likely to be discussed between mental health professionals and their clients. The first stage is a self-examination stage. During this stage, individuals examine their personal concerns and views regarding sexual issues. It is here where individuals begin to become educated about topics related to sexuality and reflect on how new information relates to their personal values, beliefs, sexual history, and current sex life. The second stage is an awareness and appreciation stage. In
this stage individuals begin to develop an awareness to sexual issues as well as the emotional reactions that clients may have when living with sex-related issues or difficulties. The third stage is where Anderson (1986) observed a newfound freedom and comfort. It is here where individuals’ willingness and comfort increased during discussions related to sexual topics. The fourth and final stage is an arrival and awareness stage. This is where individuals become aware of their comfort discussing sexually related issues, and an increased willingness emerges as they arrive within a space where sexual communication feels natural and even necessary. These stages, however, are not always reached by all healthcare providers.

Haboubi and Lincoln (2003) surveyed 100 healthcare providers and found that while 90% of participants reported sexual health to be important and a topic that should be approached, 94% of the same respondents reported that they were not likely to initiate sexually related discussions with clientele. Comfort, or lack thereof, was reported as one of the main reasons behind the lack of initiating these discussions. In addition, the majority of clinicians reported believing that they were not properly trained to facilitate communication of a sexual nature with clients. Failure to discuss sexual issues with clients due to comfort levels was reported to be more common with physicians working in female-specific care, geriatric care, and disabilities (Haboubi & Lincoln, 2003; Maciel & Laganà, 2014; Pauls et al., 2005; Thomason, Capps, Lefler, & Richard-Davis, 2015). Furthermore, Dyer and das Nair (2013) found that physicians reported increased discomfort when discussing sexually related topics with minority groups (e.g., Black or African American clients, nonheterosexual clients, clients with disabilities, and clients of aging populations).

Fuzzell, Shields, Alexander, and Fortenberry (2017) performed a methodical literature review of major databases and found dozens of articles related to young people and physician
communication regarding sexual health-related topics. Article after article found rare and infrequent communication between physicians and young individuals regarding sexual topics. Furthermore, communication regarding sexual orientation, sexual attractions, and noncoital sexual behaviors were reported to be the rarest. Every article called for change regarding the improvement of sex-related communication between healthcare professionals and young people. Additionally, in a qualitative study by Fuzzell, Fedesco, Alexander, Fortenberry, and Shields, (2016), researchers found that interviews with young individuals regarding communication with healthcare providers revealed a demand for increased quantity of sexual communication, improved quality of sexual communication, and a need for physician comfort during sex-related communication.

On a positive note, Higgins et al. (2012) found that after a one-day workshop focused on interdisciplinary approaches to sexuality, healthcare professionals reported increased levels of comfort with sexuality. Additionally, Helland, Garratt, Kjeken, Kvien, and Dagfinrud (2013) reported that healthcare providers who had training and/or education with sexuality-specific instruction felt increased comfort discussing sexual-related topics with clientele. These researchers suggest that education and/or training in sex-related topics and sexuality can have positive impacts on healthcare professionals’ comfort levels when discussing associated topics with clients.

**Mental Healthcare Providers’ Comfort with Sexuality**

Graham and Smith (1984) wrote that the mental health professional’s comfort level with sex and sexuality affects essentially every facet of clients’ comfort level when discussing said topics. Because of this, the authors declared clinicians’ sexual comfort levels to be incredibly important when working with clients. Graham and Smith (1984) also reported that when mental
healthcare professionals’ knowledge level about sexuality increased, so did their comfort levels regarding sexuality. Furthermore, Cupit (2010) reported that when mental health professionals show discomfort regarding clients’ communicating sexuality/sex, there was increased probability of topics of sex to be perceived as taboo, a decreased probability of clients reporting the desire to seek help for sex-related concerns, and an overall damage to the therapeutic relationship.

The limited research that has been done on the topic of sex and sexuality as a topic of discussion between mental health professionals and clients has had similar results, with researchers finding that when comfort levels of clinicians increase, the probability of sexual concerns being addressed and openly discussed during therapy also increases (Harris & Hays, 2008; Hartl et al., 2007; Papaharitou et al., 2008; Weerakoon et al., 2008). With that being said, there are some discrepancies in the literature as to the connection between knowledge and comfort. Some researchers have found knowledge and comfort to have a positive correlation when it comes to working with clients’ sexuality (Graham & Smith, 1984; Haag, 2008; Weerakoon et al., 2008). On the contrary, research by Harris and Hays (2008) did not find a connection between knowledge and comfort to have a positive correlation when it comes to working with clients’ sexuality.

Hanzlik and Gaubatz (2012) completed a cross-sectional study of clinical psychology students with the intention of assessing their comfort levels when working with clients who live with sexual issues. The authors reported that the participants reported low levels of comfort when it came to discussing specific sexual topics and concerns, but also reported heightened levels of comfort “when asked globally (i.e., an abstract level) about discussing sexual issues with clients” (p. 219). Hanzlik and Gaubatz (2012) also reported that participant sex identity also played a role in comfort levels with female participants reporting lower levels of comfort when
working with male clients and all participants reporting lower levels of comfort when working with female clients. Finally, the authors reported a positive correlation between comfort and sexuality training, highlighting the demand to incorporate sexuality-specific training in mental health professional educational programs.

Pukall (2009) made the argument that if mental health professionals are not comfortable discussing topics related to client sexual health, then said clinicians lack the ability to provide truly effective psychotherapy. Researchers have also shown that mental health professionals who lack comfort discussing topics of a sexual nature with clients had significant difficulty establishing a strong therapeutic relationship as well as providing comprehensive quality care (Bancroft, 2009; Kazukauskas & Lam, 2010; Moser, 2009; Nasserzadeh, 2009). Furthermore, many researchers who have investigated mental health professionals’ level of comfort engaging in discussions with clients about sex and sexuality have empirically connected comfort to willingness. This is to say that researchers have found a strong, positive association between sexual comfort and clinician willingness to engage in discussions with clients about sex and sexuality (Berman, 1996; Bulow, 2012; Hayes et al., 2020; LoFrisco, 2013).

**Mental Health Professionals’ Willingness to Discuss Sex and Sexuality**

Even though the research is few and far in between, research has been done as early as the 1970s in the field of mental health regarding clinician willingness to help and treat clients with sexual issues and concerns (McConnell, 1975, 1976). The most common variables included sexual knowledge, education and training, sex-related attitudes, sexual comfort, and clinical experience. There have been a handful of unpublished dissertations over the years that have focused on mental health professionals’ willingness to discuss sex and sexuality with clients, but there is a dearth of published materials on that same topic. One prominent study that is
continually cited is the aforementioned Harris and Hays (2008) study. These researchers attempted to discover if sexual comfort, sexuality education, and clinical experience concentrated on sexual issues, supervision experience concentrated on sexual issues, and perceived sexual knowledge were correlated to marriage and family therapists’ willingness to initiate communication regarding sexual matters. The authors also used collected demographic information to further assess the clinicians’ willingness to initiate sexual topic discussions. Sexuality education and supervision experience concentrated on sexual issues were found to be the strongest predictors for marriage and family therapists’ willingness to initiate communication regarding sexual matters (Harris & Hays, 2008). The study also found that when marriage and family therapists received increased sexuality education and supervision experience concentrated on sexual issues that participants reported increased levels of sexual comfort and sexual knowledge. Sexual comfort level was reported as the second greatest predictor, and sexual comfort levels were said to increase in those who had higher levels of perceived sexual knowledge. Cupit (2010) summarized these findings by stating, “When [marriage and family therapists] believe they have high levels of sexual knowledge, they become more comfortable with sexuality and are therefore more willing to initiate sexual discussions with clients” (p. 25).

Harris and Hays (2008) also reported a number of factors that did not directly influence marriage and family therapists’ willingness to initiate communication regarding sexual matters. Unexpectedly, clinical experience concentrated on sexual issues did not directly influence participants’ comfort with sexual content. Furthermore, participants’ actual sexual knowledge did not directly influence their willingness to initiate communication regarding sexual matters with clients. When assessing the demographic information, Harris and Hays (2008) reported that gender, age, discipline, level of education, years of practice, and number of clients seen per week
also did not influence clinicians’ willingness to initiate communication regarding sexual matters with clients. On the contrary, increased sexuality education and supervision experience concentrated on sexual issues in fact did increase clinicians’ willingness to initiate communication regarding sexual matters with clients. These results were regardless of the clinician’s gender, age, discipline, level of education, years of practice, and number of clients seen per week. Because of these findings, it came as no surprise that clinicians who were educated and trained as certified sex therapists were more willing to initiate communication regarding sexual matters with clients than noncertified sex therapists.

Miller and Byers (2012) reported some contradicting findings when they recruited psychologists as their participants. As previously stated, only 40% of assessment and intake clients were directly asked about sexual concerns, and only 22% of clients being treated were asked about and/or treated for sexual-related concerns. Miller and Byers (2012) did, however, find that age was a contributing factor, reporting that “older psychologists and psychologists who had been practicing for longer were somewhat (accounting for less than 7% of the variance) more willing to address sexual issues” (p. 1047). Træen and Schaller (2013) reported similar findings in a Norwegian study of 2,352 clinical psychologists, writing that psychologists who were older were more willing to discuss sexual issues with their clients. They also found that about 20% of the participants reported they often or always initiate their clients regarding sex and sexuality.

Despite the significance, sex and human sexuality is often avoided altogether or approached incredibly cautiously throughout the counseling process (Parritt & O’Callaghan, 2000; Southern & Cade, 2011). Fortunately, Flaget-Greener, Gonzalez, and Sprankle (2015) reported that increased sex-related education and training was able to independently predict
clinician willingness to discuss sexual health-related topics with clients. Finally, Moore (2018) found that there was a positive relationship between therapists’ levels of sexuality training and therapists’ willingness to communicate with clients regarding sexual topics. This means, “as graduate sexuality training increased, there was a corresponding increase in a therapist’s willingness to discuss sexual topics” (p. 95). Research has also shown that clinicians’ attitudes toward sex and human sexuality can also strongly influence their conversations with clients regarding these issues.

**Mental Health Professionals’ Attitudes Regarding Sex and Sexuality**

An additional important factor that can impact a healthcare professional’s comfort and willingness to discuss topics related to sexual health is attitude (Papaharitou et al., 2008). Attitudes are impressions and conceptions that individuals apply to societal objects or actions that have been formed due to values and ideals throughout a lifetime (Hitlin & Piliavin, 2004). Weerakoon and Stiernborg (1996) stated that healthcare professionals’ sexual values and attitudes have the potential to affect their interactions when working with clients. Hilton (1997) wrote that therapists’ personal experiences and values affect attitudes pertaining to clients’ sexual issues. The author also wrote that through self-awareness and training, anxiety can decrease, comfort can increase, and an increased willingness to engage in topics pertaining to sexuality can start. Anderson (2002) found a significant correlation between sexual attitudes of licensed professional counselors and their sexual comfort levels. This is to say that counselors who identified themselves as having more liberal sexual attitudes were found to also have a higher degree of sexual comfort when working with clients.

Papaharitou et al. (2008) surveyed 714 future healthcare professionals and found that personal values, gender, and experiences all influenced participants’ attitudes regarding sexual
issues. Furthermore, the authors found that attitude plays an important part of the development that has the potential to increase a clinicians’ comfort and willingness to discuss sexual health issues with their clients. Papaharitou et al. (2008) also wrote that because negative attitudes have the potential to hinder effective sexual health treatment, it is essential that all health professions integrate coursework regarding effective communication and human sexuality in order to increase future clinicians’ awareness when it comes to their personal sexual prejudices and values. Juergens (2006) found that sexual education and sexual knowledge affected attitudes and that sexual attitudes in turn affected clinicians’ comfort levels discussing sexuality with clients. Finally, Cupit (2010) surveyed 224 members of the American Counseling Association and found that sexual attitudes were significantly related to sexual comfort. Cupit (2010) went on to write that sexual attitudes “imply that the more communion or idealistic attitude counselors have about sex, the greater their sexual comfort” (p. 113).

Valvano et al. (2014) studied 479 participants from a number of different healthcare professions regarding human sexuality issues. Said authors wrote that negative attitudes regarding sex and human sexuality have potential for detrimental impacts on patients and clients and that clinicians’ attitudes toward sexual health have direct links to sexually specific health training. Contrary, in a recently study, Moore (2018) found no significant correlation between therapists’ sexual attitudes and their willingness to discuss sexual-related topics with clients. The author goes on to acknowledge that his findings are in contrast with most major studies studying the shared variables. The author was unable to explain said findings. Due to the recent contrast in findings, the current study will hopefully shed light on current trends when it comes to mental health clinicians’ sexual attitudes and the relationship these attitudes have to college counselors discussing sex and human sexuality-related topics with clients.
**Education and Training**

For decades mental health researchers have emphasized the importance of mental health professionals’ human sexuality education and comprehension, sex-related clinician components and training, and the role that sexual awareness and attitudes play when working with clients (Fyfe, 1980; Gray, Cummins, Johnson, & Mason, 1989; Gray, House, & Eicken, 1996; Kirkpatrick, 1980). More recent research has shown that mental health professionals who receive sexuality education and training report increased comfort and willingness to discuss sexual health-related topics with clients (Cupit, 2010; Flaget-Greener et al., 2015). Human sexuality and education have also been shown to improve clinicians’ sexual attitudes and in turn their willingness to have sex-based communication with clients (Juergens, 2006). Unfortunately, the majority of mental health clinicians do not receive sex or sexuality-related education or supervised clinical training (Gregory & Paylo, 2020; Reissing & Giulio, 2010). Hayes et al. (2020) found that when there is increased training or educational experiences, participants found increased comfort levels communicating sexual matters with clients. Miller and Byers (2009) reported that mental health professionals with more overall continuing sex education and training were also more prone to initiate communication regarding sexual matters with clients and more willing to treat clients with sexual issues. Furthermore, Miller and Byers (2008) suggested that continuing education may produce feelings of competency and professional confidence that in turn encourages clinicians to initiate discussions regarding sexual matters with clients.

Reissing and Giulio (2010) studied practicing clinical psychologists and found that more than half of the participants found no graduate education or postgraduate training that focused on sexual health or human sexuality. The authors went on to describe how comfort discussing sexuality with clients was significantly related to the intensity of sexuality education and
training. This is to say, “the more training psychologists had received, the more comfortable they were discussing sexuality with their clients” (p. 59). Furthermore, Miller and Byers (2010) found that of the 162 psychologists who participated in their research, nearly 70% reported never to have taken a single graduate-level course related to human sexuality. Finally, Burnes, Singh, and Witherspoon (2017) found that only 16% of the counseling psychology doctoral programs they studied offered a course devoted entirely to human sexuality, with most being offered as an elective. The authors also point out that only about half of the participants reported offering at least one course that included one or more sexuality-related topics. Unfortunately, upon further investigation it was discovered that the majority of these courses reported minimal and limited coverage of sex-related topics (e.g., a single lecture or reading throughout the duration of an entire course; Burnes et al., 2017). The authors also found that about a third of the participating psychology doctoral programs reported that none of the courses offered contained human sexuality content.

The studying of human sexuality education and training in counselor education programs, although rare, dates back decades, with one of the first being in 1980. Kirkpatrick (1980) reviewed 40 counseling graduate program curriculums and found that none of the randomly selected programs offered a course focused on human sexuality. Gray, Cummins, Johnson, and Mason (1989) reported that a majority of counselor education programs did not require or even offer education or training in human sexuality and counseling. Gray, House, and Eicken (1996) questioned 243 counselor education program directors and determined that only 20% of participating programs offered specific courses related to human sexuality. Furthermore, Gray et al. (1996) noted that even though some of the participating courses did incorporate specific lessons to human sexuality, “many educators are not systematically including such information
into their training” (p. 215). Human sexuality in counseling over the last two decades has transformed into more of a constructivist perspective (Paiva, 2005; Southern & Cade, 2011; Tiefer, 2006; Trimble, 2009). It is also unfortunate that not much research has been done regarding the inclusion of human sexuality in counselor education programs since Gray et al. in the 1980s and 1990s.

Ford and Hendrick (2003) surveyed members of the American Psychological Association (APA) and the American Association for Marriage and Family Therapy (AAMFT) regarding their education and training related to mental health, clients, and sexual issues. The authors found that 22% of the participants reported having never received training for clients with sexual issues, and 41% reported having never received training when it comes to conducting a sexual history and/or assessment. When participants where asked about the quality of education and training, “the mean response was 3.0 on a 1–5 point scale (SD = 0.96), indicating a neutral response” (p. 83). Ford and Hendrick (2003) were able to report an increase in education in training regarding sexual issues and human sexuality among mental health professionals, although the quality of said training was not rated favorably.

Wiederman, Sansone, and Sansone (1999) probed over 300 psychology doctoral students from a variety of programs and found that less than 18% of participating doctoral students reported any type of didactic course training regarding sexuality. Furthermore, only 11% of participants reported having didactic training during their internship experiences that included sexuality topics. Miller and Byers (2008) surveyed 172 students enrolled in a number of clinical psychology graduate programs in the United States and Canada and found that nearly 85% of participants reported seeking out independent resources due to the lack of sexuality training in their programs. Furthermore, the authors reported that while participants did not expect to have
extensive human sexuality education at the graduate level, the average response for didactic training and education was reported between *Not Covered* and *Somewhat Covered*. Finally, the authors wrote that they believed the current level of didactic education and training experiences related to sexuality in psychology graduate programs is not thorough enough for mental health professionals to feel confident in addressing clients’ sexual issues and concerns. Therefore, Miller and Byers (2008) predict that if mental health students are not afforded opportunities to develop human sexuality-related self-efficacy within their graduate programs, said students will likely be unwilling to address sexual concerns with future clients.

Dupkoski (2012) reported that upon reviewing 395 syllabi posted to the ACA-ACES Syllabus Clearinghouse, less than 10% included the word “sex” anywhere in the syllabus and only about one percent focused on human sexuality. Valvano et al. (2014) surveyed nearly 500 healthcare students from different specialty areas and found that psychology students received the least amount of education and training related to sexuality, with nearly 70% of participants reporting no human sexuality coursework in said topic. The authors went on to note that not only was the quantity of sexual education shockingly low, but even the programs that did provide some sexual education and training lacked quality sexual education. Jaramillo (2016) surveyed 166 counseling students and found that less than 50% had ever taken or were currently enrolled in a graduate-level counseling course focused on human sexuality. Furthermore, more than 20% of the counseling student participants reported they had never attended a single class, course, or workshop that focused on human sexuality.

Lastly, Gregory and Paylo (2020) surveyed more than 900 licensed counselors regarding their sexual history taking practices. The results of this study indicated that only 37% of participants reported a belief that their counselor training prepared them to take a sexual history
from a client during an intake or initial session. The authors also reported that 75% of participants agreed that counselor training programs do not provide enough education on how to discuss sexual history with clients. Furthermore, only about 30% of the licensed counselor participants believed they had been taught the importance of a client’s sexual history; only about 15% of said participants reported having learned how to take a sexual history from their academic programs (Gregory & Paylo, 2020).

**Mental Health Professionals Taking a Sexual History**

According to the aforementioned research study by Gregory and Paylo (2020), results from more than 900 licensed counselors revealed that more than 70% of surveyed counselors agreed that taking a sexual history from clients was important, and 93% agreed that it was important for counselors to know how to take a sexual history from new clients. In the same study, Gregory and Paylo (2020) discovered that more that 55% of the counselors surveyed believed that they did not take a thorough sexual history from new clients. In short, most counselors believe it is important to take and to know how to take a sexual history from new clients, but more than half of all counselors do not believe they take and have been trained to take a sexual history during an intake or initial counseling sessions (Gregory & Paylo, 2020).

This current research focuses on practices in college counseling. Klein, Goldenring, and Adelman (2014), all medical doctors who work with teens and young adults, reported that talking to young adults about their sexual history can be the most sensitive subject during an early appointment. The lack of sexual history taking when working with young adults was evidenced further by Goyal, Witt, Hayes, Zaoutis, and Gerber (2014) when the medical doctors were assessing clinicians’ observance of standards in documenting sexual histories for teens and young adults. The researchers found that of the 1,000 patient files that were reviewed, only 212
had a documented sexual history (21.2%). An argument can be made that many of the patients were younger than the typical college-age student, but this still does show a lack of sexual history being taken from young individuals in a health-related field. When comparing the field of medical health to the field of mental health, much of the previously stated research has already revealed that sexual history taking practices between the medical field and the mental health field tend to be similar (Abramsohn et al., 2013; Althof, Rosen, Perelman, & Rubio-Aurioles, 2013; Giami & Pacey, 2006; Kingsberg, 2004; Lindau et al., 2012; Lindau et al., 2007; Marwick, 1999; Mallicoat, 2014; Nasserzadeh, 2009; Southern & Cade, 2011; Wimberly, Hogben, Moore-Ruffin, Moore, & Fry-Johnson, 2006).

Two decades ago, researchers were connecting social learning theory (SLT) to individual differences in human sexual expression (Hogben & Byrne, 1998). The researchers used SLT to describe historical and modern links between said theory and four broad sexuality-related topics: 1) coercive sexuality, 2) health-related sexual behavior, 3) sexuality development, and 4) adolescent sexuality and contraceptives. The Resource Center for Adolescent Pregnancy Prevention (ReCAPP, 2018) utilizes SLT to change behaviors for prevention-based sexuality programs. ReCAPP states that sex is influenced by individual knowledge, attitudes, skills, environmental influences, and interpersonal relationships (i.e., aspects of SLT). This organization echoes the argument that “teens receive few, if any, positive models for healthy sexual behavior” (p. 3). ReCAPP is on a mission to model more healthy communication and behavior related to sex and human sexuality, actually linking SLT and sexual health in action.
Social Learning Theory

Bandura (1977), via social learning theory (SLT), suggests that individuals learn from one another via imitation, observation, and modeling. Bandura’s theory corresponds with classic behaviorist learning theories of conditioning; however, he complements these classic concepts with two additional significant concepts. First, Bandura concluded that mediated processing occurs between responses and stimuli, and second, behavior is learned from settings and environments through a process called observational learning. Observational learning, simply put, is when individuals observe others around them behaving in a variety of manners, and due to this exposure, the observers will imitate the models’ behaviors. If the observer's imitated behavior is rewarded and/or reinforced, the observer is likely to continue said behavior. On the contrary, if the observer’s imitated behavior is not rewarded or is reprimanded, the observer is less likely to continue the behavior. It is important to remember that reinforcement can be internal or external, as well as positive or negative (Bandura, 1963). Some of the key concepts of SLT are as follows:

- Learning is more than behavioral. Learning is a cognitive process that happens within a social context.
- Learning occurs by observing behavior as well as by observing the rewards and/or consequences of the behavior. This is frequently referred to as vicarious reinforcement.
- Learning engages observations, processing information from the observations, and decision making regarding the implementation of behavior. This is referred to as observational learning or modeling.
• Reinforcement is partly responsible for learning but is not completely responsible for learning.

• Learners are not inert recipients of information. Environment, behavior, and cognition are all simultaneously influencing one other. This is often referred to as reciprocal determinism (Grusec, 1992)

**Underlying Cognitive Processes and Modeling**

Modeling, as previously described, is a heavily utilized concept in social learning theory. Bandura (1986) described three styles of modeling stimuli: 1) live models, 2) verbal instructions, and 3) symbolic. Live models are when an individual demonstrates the desired behavior. Verbal instructions are when individuals describe the desired behavior. This is often done with instructions and details that describe the desired behavior from the participant. Symbolic is when modeling happens via media. This includes, but is not limited to, stimuli from the Internet, television, movies, and social media (Chen & Bryer, 2012).

Cognitive and behavioral processing determines which observed information and behaviors are deemed influential (Bandura, 1972). These processes are referred to as attention, retention, reproduction, and motivation. Attention is when an observer attends to the behavior that is modeled and something is learned. Attention is influenced by physiognomies of the observer. Examples of these are past performances, cognitive ability, arousal, and perceptual ability. Attention is also influenced by physiognomies of the behavior. Examples of these are functionality, novelty, significance, and emotional valence. These are the ways in which social factors influence attention.

Bandura (1972) describes retention as ways in which the observer remembers the topographies of the behavior or event. This is how it is possible for the observer to reproduce this
observed behavior. Once again, these processes are influenced by characteristics of the observer. Examples of this are cognitive rehearsal as well as cognitive capabilities. Finally, event characteristics like behavior complexity can also influence retention. Visual and verbal cognitive processes are the underlying modalities for retention by the observer.

When it comes to reproduction, Bandura (1972) describes reproduction as the actual implementation of the model and not the proliferation of it. Because of the cognitive skill that is often required during this stage, often there is a need for sensorimotor abilities. Because of this, reproduction can have a tendency to be difficult to reinforce after observation. There are behaviors and events that cannot be reproduced due to capability or lack thereof. Often reproduction can require input from additional individuals in order to offer corrective feedback. More recent research has added to Bandura’s scheme of reproduction by evidencing that motivation of the observer and effective feedback from additional individuals are also factors that can affect reproduction (Wang & Wu, 2008). A simple example of this process is a coach/trainer and an athlete.

The motivation is the desire to reproduce or, in contrary, not to reproduce the observed behavior (Bandura, 1972). This is contingent on the expectations as well as the incentives for predicted consequences and internal criteria. Bandura (1972) described motivation to also be contingent on social factors and environment. This is because motivational factors are influenced by functional values that various behaviors and events are allocated by this environment. This means when certain behaviors are deemed as positive and/or favorable, the motivation to reproduce this behavior will strengthen. Alternatively, when behaviors are deemed undesirable and/or unwelcome, the motivation to reproduce said behavior will diminish. This study
attempted to identify whether there is a correlation between social learning and a college counselor’s probability to complete a thorough sexual history with clients.

**Social Learning Theory in the Workplace**

Research dating back to the 1970s has shown that social learning theory holds a level of responsibility when it comes to career decisions and professional behaviors (Krumboltz, Mitchell, & Jones, 1976). Recent research has even shown that SLT not only impacts behaviors displayed by individuals within a work environment but that workplace ethical behaviors impact the ethical behaviors of employees (Zahra, Ahmad, & Waheed, 2017). Even though this study does not have a central focus on ethics, it is an interesting time in American history due to the #MeToo and #TimesUp movements. One may be interested to see if these movements and the recent focus on sexual harassment in the workplace could further hinder the probability of counselors to take a thorough sexual history due to fear of misunderstandings and prosecution. This is to say that if an employee is modeling certain behaviors, according to SLT, they are more likely to exhibit similar behaviors (Bandura, 1963).

If mental health professionals are not shown, trained, or educated to ask clients about sexual history, these mental health professionals (due to attention, retention, reproduction, and motivation) are less likely to complete a sexual history with their clients. Gregory and Paylo (2020) strengthen this argument by reporting that more than 50% of counselors reported that the counseling training they have received has not prepared them to take a sexual history, and nearly 55% of counselors reported that they were never taught during training as a counselor that it is important to take a client’s sexual history. Also, due to the fact that many individuals believe that sexual issues, dysfunctions, and disorders are associated with the aging population (Laumann & Waite, 2008; Taylor & Gosney, 2011), college counselors may be even less likely to take a
thorough sexual history. It is also believed that perhaps mental health professionals working in college counseling centers are less likely to assess for sex and sexuality-related issues due to the plethora of issues that typical college students are already experiencing.

**College Counseling**

According to the Council for the Advancement of Standards (CAS) in Higher Education, (2015), “The primary mission of Counseling Services (CS) is to assist students in defining and accomplishing personal, academic, and career goals” (p. 6). In order to accomplish this, university and college counseling centers offer a number of services including, but not limited to, individual and group counseling, developmental focused programming, advocacy, assessment services, and crisis response (CAS, 2015). The field of college counseling is unique in a number of ways given the exceptional stressors and highly contextualized settings (Rosenbaum & Weatherford, 2017; Stephens, Townsend, Hamedani, Destin, & Manzo, 2015; Yan, Li, & Sui, 2014). Research has shown that in recent years university and college student mental health issues appear to be higher than ever (Cohen, Graham, & Lattie, 2020; Ketchen, Lipson, Gaddis, Heinze, Beck, & Eisenberg, 2015).

**College Counseling Center Population**

As of fall 2020, there were about 19.7 million students who attended colleges and universities in the United States (National Center for Education Statistics, n.d.), with the majority of the students, especially undergraduates, being young adults (i.e., under the age of 25). Lockard, Hayes, Neff, and Locke (2014) conducted a study with 1,609 participates who were university or college counseling center clients from 132 universities/colleges across multiple states. The authors found that even though the total age range was from 18 to 63, the average age was 22.74 years and about 85% of participants were 25 years of age or younger. This study
provides further justification for utilizing college counselors when studying the counseling sessions of young adults. There is also the breakdown of individuals who work at college counseling centers.

Reetz, Bershad, Leviness, and Whitlock (2015), via the Association for University and College Counseling Center Directors, surveyed a total of 529 counseling centers across the United States. The authors provided a great deal of information regarding the makeup of counseling center staff as well as services provided to students. Within the report, the authors found that among the full-time staff, about 28% of the mental health professionals were identified as clinical psychologists, about 26% were identified as counseling psychologists, about 20% were identified as professional counselors, and about 15% were identified as social workers, leaving roughly 11% to be made up of other mental health professionals (e.g., marriage and family therapists, psychiatrists, psychiatric nurse practitioners). Due to this breakdown of mental health professionals as well as official training and licensure held, it is important for the current research to expand beyond simply the study of licensed professional counselors working in college counseling centers. It is for this reason the current research focused on any and all mental health professionals providing counseling services who are working in college counseling centers.

There are a number of reasons why college mental health is consistently changing and remains the focus of much research. According to the National Alliance on Mental Illness (2016), nearly 755 mental health issues start by age 24. This means a number of university and college students are living with mental health issues for the first time, and many do not know where to turn for help. Another frequently referenced explanation to the changing mental health climate in this population is the reduced stigma surrounding mental health disorders and
treatment (Hackler, Cornish, & Vogel, 2016; Kosyluk et al., 2020; Michaels, Corrigan, Kanodia, Buchholz, & Abelson, 2015). University and college students often experience a number of different mental health disorders typical of the general population, but there are also a number of mental health issues and disorders that are more prevalent within the postsecondary population (Locke, Wallace, & Brunner, 2016; Stock & Levine, 2016).

**Client Issues in College Counseling**

Levine and Dean (2012) reported that more and more university and college students across the country are utilizing counseling services and that the modern college student is living with longer term and deeper problems than those of previous generations. Furthermore, the authors reported that during the first decade of the 21st century, there was a 90% increase in college students who experienced mental health issues. Finally, Levine and Dean (2012) reported that 77% of the colleges and universities who participated in their study had significantly increased their use of psychological counseling. There are a variety of reasons why students are seeking services from college counseling centers at a higher rate.

Stress and anxiety have been issues for university and college students for decades (Beiter et al., 2015; Meichenbaum, 1972; Mena, Padilla, & Maldonado, 1987; Misra, McKeen, West, & Russo, 2000; Rawson, Bloomer, & Kendall, 1994), so it comes as no surprise that these remain issues with students today (Locke, Wallace, & Brunner, 2016; Posselt & Lipson, 2016; Stock & Levine, 2016; Yeboah et al., 2020). According to the American College Health Association (2017), over 85% of college students have felt significant levels of stress in the past year, with nearly 50% rating their stress levels as either “more than average stress” or “tremendous stress” (p. 16). Furthermore, according to the same report, more that 20% of college students were found to be undergoing treatment for and/or diagnosed with some kind of anxiety
disorder by a professional within the last year. According to these statistics, stress and anxiety remain the highest reported mental health issues plaguing college students (American College Health Association, 2017).

Depression has been and remains a major mental health issue for college and university students across the United States (Hammen, 1980; Storch, Roberti, & Roth, 2004; Wang et al., 2008). According to the American College Health Association (2017), 67.3% of students reported recently feeling “very sad,” 51.1% reported feeling “things were hopeless,” and 39.1% reported feeling “so depressed that it was difficult to function” (p. 13-14). Unfortunately, both the statistics for feelings of hopelessness and depression have risen significantly in the last several years (American College Health Association, 2013). More recent studies have also shown a link between college students with depression and a variety of harmful coping mechanisms including, but not limited to, alcohol use and abuse (Bravo & Pearson, 2017), stimulant medication misuse (Benson & Flory, 2017), social isolation (Chow et al., 2017), and nonsuicidal self-injury (Cramer, LaGuardia, Bryson, & Morgan, 2017). Not all self-harm is non-suicidal, and unfortunately, we continue to see an increase in suicidal ideation and attempts within the university and college student population.

For decades, university and college student populations have seen an increase in suicidal ideation and intent when compared to the general population (Hayes et al., 2020; Ross, 1968; Schwartz, 2006; Westefeld, Whitchard, & Range, 1990). In a study by Mortier et al. (2018), researchers reported that about one-fourth of college and university students experience some kind of suicidal ideation and that nearly 65% of these individuals reported suicidal ideation within the past year. The study went on to report that of the 25% of students who did report some kind of suicidal ideation, between 40% to 45% indicated they had a plan and about 20% reported
some kind of suicide attempt. According to the Centers for Disease Control and Prevention (CDC, 2016), suicide is the second leading cause of death for typical college age students. Furthermore, suicide has increased to the second leading cause of death for individuals in the United States between the ages of 10 and 34 (CDC, 2016).

University and college students as of late are reporting trauma and traumatic events more often than we have seen in the past (Cox, Dean, & Kowalski, 2015; Cusack et al., 2020; Flynn, & Sharma, 2016; Locke, Wallace, & Brunner, 2016). Boyraz, Horne, Armstrong, and Owens (2015) reported that more than 68% of university and college freshmen reported at least one traumatic event happening within their lifetime. This indicates that many university and college students are entering their studies already having been exposed to trauma. If this is not bad enough, many students experience trauma on campus.

Individuals attending colleges and universities are more likely to be sexually assaulted than the general population (RAIN, 2018). Sexual assaults for many individuals are traumatic events (Scott et al., 2018) that happen on or around university and college campuses across the United States. Flynn and Sharma (2016) also discussed a number of events that happen more recently on college campuses that have serious traumatic repercussions, including, but not limited to, natural disasters, vehicular and transportation accidents, campus shootings, and/or campus accidents and tragedies. Flynn and Sharma (2016) explained how these tragedies “brought widespread distress to the university community, to those connected to the campus community from a distance, and to the wider world who were witness to tragedy though media exposure” (p. 78).

Gallagher (2014) found that 94% of respondents from across the country reported an increase of college and university students with severe psychological problems. The same study
showed that 52% of college counseling center clients are documented with severe psychological problems. The top-reported issues include, but are not limited to, anxiety disorders (89%), crises requiring immediate care (69%), psychiatric medication-related issues (60%), clinical depression (58%), sexual assault (43%), and self-injury (35%). Gallagher does mention sexual assault and abuses, but nowhere in the document does the report address the current and proven issues that previously mentioned researchers have shown to be increasing among young adults and typical college-age students.

The challenges posed for the mental health education, training, and supervision community consist of the lack of education and training when it comes to sexual history taking within the college counseling setting. The problem this study is attempting to address is the growing demand for college counselors to take thorough sexual histories when working with college and university students. This concern includes the lack of mandating for sexuality counseling by current CACREP standards (CACREP, 2015) as well as the counselors’ reasoning for diagnosis and treatment (Bogels, 1994; Jones, 2010; Mead, Hohenshil, & Singh, 1997). College is such a stressful time in one’s life (Stephens, Townsend, Hamedani, Destin, & Manzo, 2015; Yan, Li, & Sui, 2014; Yeboah et al., 2020), and college counselors have many responsibilities when it comes to assessing the possible mental health issues of their clients. College counselors must assess for a variety of concerns, many of which mentioned above. Given the number of common university and college student mental health issues that could arise, as well as the outdated and incorrect belief that sexual issues do not affect young adult populations (Laumann & Waite, 2008; Moreau, Kagesten, & Blum, 2016; Taylor & Gosney, 2011), one can see why a sexual history and sex-related issues may not be assessed.
Summary and Conclusion

Throughout this chapter, the literature review has elaborated that even though there is an importance and need for mental health clinicians working on college campuses to have sex-related discussions with clients, it is likely that these discussions are lacking and hindered. Researchers over several decades have found a variety of evidence linking the lack of or hindered sex and human sexuality discussions to low and reduced comfort, willingness, and attitudes stemming from the overall lack of education and training of mental health clinicians regarding the topic of mental health’s connection to sex and human sexuality. Finally, in this chapter, I described the theoretical framework on which the research study was based (i.e., social learning theory) and how that theory may partially explain the lack of sex and human sexuality communication taking place between mental health clinicians and their clients. At this time, there are no published materials focused on sex and human sexuality-related communication or sexual history taking by mental health professionals employed by universities and colleges working with college-student clients. The current study used a descriptive, survey research design to obtain information on this topic. Chapter 3 will include details to the study’s methodology.
CHAPTER 3: METHODOLOGY

Purpose

The following chapter explains the methodology that was utilized for the inferential survey research study conducted. The purpose of this research study was to examine variables that may impact college counselors’ probability to take a sexual history from clients. The overarching research questions are: What is the relationship between college counselors’ sexuality education and the probability they will take a client’s sexual history? And what is the relationship between college counselors’ comfort level, willingness, and attitudes regarding sex-based therapeutic conversations with clients and the probability they will take a client’s sexual history? This information has the potential to add substance to the literature regarding counselor education and supervision, counselor training, and the field of college counseling around a growing clinical need.

One independent variable in this study was the human sexuality education and train of mental health professionals working in college counseling centers (i.e., Research Question 2). This variable is a construct variable and was assessed utilizing Ariffin et al. (2015). This variable was measured using an ordinal measurement (1- Strongly agree, 2- Moderately agree, 3- Neither agree nor disagree, 4- Moderately disagree, 5- Strongly disagree). The comfort level, willingness, and attitude variables were also utilized as an independent variable (i.e., dependent = Research Question 2). These variables were run together also as a construct variable. These variables were measured using an ordinal scale (1- Extremely comfortable, 2- Moderately comfortable, 3- Neither comfortable nor uncomfortable, 4- Moderately uncomfortable, 5-
Extremely uncomfortable). The dependent variable in this study was college counseling center health professionals’ probability to complete a sexual history with clients (i.e., Research Questions 1 and 2). This was also assessed using an ordinal scale (1- Extremely likely, 2- Somewhat likely, 3- Neither likely nor unlikely, 4-Somewhat unlikely, 5- Extremely unlikely). This variable was also a construct variable.

Throughout this chapter, I describe the research design as well as the study’s instruments. I also offer the population, sample size, and sampling procedures for the study. Next, I specify information on data collection, measurement instruments, operationalization of variables, and data analysis. Finally, I address possible limitations and possible threats to validity.

**Research Design**

A descriptive, survey research design (i.e., quantitative study) was chosen in order to examine the prevalence of college counselors completing sexual history assessments with clients. Additionally, this study assessed how human sexuality education and training impacts college and university counselors’ comfort, willingness, and attitudes toward having sex-based communication with clients. In addition, an explanatory correlational design was employed. More specifically, this research design will address the following questions.

**Hypotheses and Research Questions**

**Research Question 1:** What is the relationship between college counselors’ sexuality education and the probability they will take a client’s sexual history?

**H1:** College counselors who report higher levels of human sexuality education and training will report a stronger probability to take a sexual history from clients.
Research Question 2: What is the relationship between college counselors’ comfort level, willingness, and attitudes regarding sex-based therapeutic conversations with clients and the probability they will take a client’s sexual history?

H2: College counselors who report higher comfort levels, willingness, and attitudes regarding sex-based therapeutic conversations with clients will report a stronger probability to take a client’s sexual history.

Participants and Procedures

The target population for this study was licensed mental health professionals working at accredited university or college counseling centers in the United States. For a university or college to be accredited, said institution must have been officially authorized or approved by an official and professional accreditation organization (Eaton, 2015). Primarily, most universities and colleges were accredited by one of six regional accrediting agencies, which have been recognized by the Council for Higher Education Accreditation and the Department of Education. These include the New England Association of Schools and Colleges, North Central Association of Colleges and Schools, Northwest Commission on Colleges and Universities, Middle States Association of Colleges and Schools, Southern Association of Colleges and Schools, and Western Association of Schools and Colleges (Eaton, 2015). In addition, specialized institutions may have an accrediting agency that was nationally recognized for the specified area of study. A full list of nationally recognized accrediting organizations can be found on the Council for Higher Education Accreditation and the Department of Education websites.

The Sexual Training Scale (Behun et al., 2017), the Comfort and Willingness Scale (Harris & Hays, 2008), the Brief Sexual Attitudes Scale (Hendrick, Hendrick, & Reich, 2006), and the Sexual History Taking Scale (Ariffin et al., 2015), as well as a short demographics
questionnaire, were administered to the voluntary participants (i.e., university and college counselors). These individuals were currently licensed mental health professionals who currently work at the aforementioned universities and counseling centers across the United States. After obtaining the IRB approval (IRB: HS21-0412), I utilized purposive and snowball sampling. Specifically, I distributed the survey via professional organizations’ listservs (e.g., American College Counseling Association). Interested participants were instructed to give consent by positively consenting to an informed consent that was presented via Qualtrics prior to the survey. Friendly reminders were sent to the listservs and possible participants to increase probability of participation. Individuals had the opportunity to voluntarily participate in the study, and no participation commendation was offered. I provided appropriate information about the IRB approval and process as well as general data regarding the population and purpose of the study.

As previously stated, the survey was distributed via Qualtrics.

A total of 77 participants was the minimum number of participants required for a multiple linear regression with a moderate effect size and a low probability of type II error. This was determined using the G* Power 3.1 program and using a power of .080 and a .05 alpha. Given that any given sample size is variable and depends on a particular statistical test, the following breakdown of the sample size was required for both individual research questions/hypotheses.

Regarding Research Question 1 and hypothesis (H₁), a sample size of 55 was the minimum number of participants required for a simple linear regression with a moderate effect size and a low probability of type II error. The minimal sample size was determined using the statistical computer program G* Power, a priori, with a threshold of alpha (α) at 0.05, statistical power (β) at 0.80, and 0.15 effect size (d, moderate effect size). This was calculated using two as the number of predictors (i.e., human sexuality education and training).
Regarding Research Question 2 and hypothesis (H2), a sample size of 77 was the minimum number of participants required for a multiple linear regression with a moderate effect size and a low probability of type II error. This n=77 again was determined using the statistical computer program G* Power, *a priori*, with a threshold of alpha (α) at 0.05, statistical power (β) at 0.80, and 0.15 effect size (d, moderate effect size). This was calculated using three/four as the number of predictors (i.e., comfort levels, willingness levels, and attitude levels).

Qualtrics is the online survey creation and administration program where the scales, a demographic survey, an informed consent form, and debriefing form were copied, and administered for participants to complete, and ultimately used in this proposed study (Qualtrics LLC, 2016). Qualtrics also collates these live surveys in a link, which were then administered via email to college counselors and were completed in a truly anonymous and de-identified fashion. This data collection method further helped to maintain anonymity as the survey’s administration features allow for a de-identification feature when administering the survey’s link to participants through email. No anticipated costs were estimated for the usage of this annual edition of Qualtrics. In addition to the data collection method mentioned, the online Statistical Package for the Social Sciences Program version 28.0.0.0 (SPSS) from IBM was used for this study’s data analysis. SPSS is a social science data analysis program that ran the tests needed for this study, including the descriptive statistics, Pearson R correlations, and other inferential statistical analyses such as the analysis of a standard multiple linear regression (Bent, Nie, & Hull, 1970).

**Scales**

Behun et al. (2017) developed a scale to assess professional school counselors’ preparedness to provide counseling on subjects connected to human sexuality when working with students in a school setting. The Professional School Counselors' Perceptions of
Preparedness to Counsel Students on Human Sexuality Scale did not directly apply to college counseling; it was developed for school counselors. Because of this, minor changes in wording were made in order to make the scale applicable for this research study (the title “school counselor” was changed to “mental health professional”). Prior to the creation of this scale, Behun, Cerrito, Delmonico, and Campenni (2017) claimed there was no preexisting measure for counselors in “preparation programs and how those perceptions contributed to their knowledge, skills, and self-awareness related to human sexuality” (p. 9). The results of this article was a new singular scale combining the relevant items from five subscales assessing multiple domains of human sexuality education and training (i.e., sexual behaviors, sexual health, sexuality and morality, sexual identity, and sexual violence). The questions were then arranged to assess directly for knowledge, skills, and self-awareness in relation to the previously mentioned subscale themes. This resulted in a single scale utilizing 15 items that assess human sexuality education and training. The study was then piloted prior to it being used by the researchers in order to improve the content and construct validity. The scale utilized a 7-point Likert scale. Cronbach’s alpha levels were reported for each content item among the human sexuality domains (knowledge $\alpha = .087$, skills $\alpha = .088$, and self-awareness $\alpha = .092$). An adapted version of the Professional School Counselors’ Perceptions of Preparedness to Counsel Students on Human Sexuality Scale (Behun et al., 2017) was used to measure college counselors’ preparedness (i.e., education and training) to counsel college students on human sexuality issues for this study.

In order to address the independent variable (i.e., comfort, willingness, and attitude levels) in Research Question 2, the Harris and Hays’ (2008) 46-item Comfort and Willingness scale and the Hendrick et al. (2006) Brief Sexual Attitudes Scale were utilized. Harris and Hays
Harris and Hays (2008) developed their scale to measure how comfortable and willing a mental health clinician would be when discussing sexual topics with their clients as well as their willingness to engage in sexual-related topics with clients. This scale is broken down into three subscales with one 19-item subscale focusing on willingness and two separate subscales, one 17-items and one 10-items, measuring comfort. The scale used a 5-point Likert-type scale in three different ways. During the first section of the survey, the scale assesses frequency of topics discussed during therapeutic conversations with clients, ranging from “never” to “very often.” The second section assesses comfort discussing sexuality issues with clients during therapeutic conversations, ranging from “very uncomfortable” to “very comfortable.” The third section assesses the clinician’s reactions to the specific statements related to sexual topics, ranging from “strongly disagree” to “strongly agree.” Harris and Hays (2008) reported a Cronbach’s alpha of $\alpha = 0.86$.

The Hendrick et al. (2006) 23-item Brief Sexual Attitudes Scale was utilized to address the independent variable in research question two. There are four distinct categories of sexual attitudes that the Brief Sexual Attitudes Scale assesses: permissiveness (i.e., openness toward an open relationship), birth control (i.e., responsibility regarding birth control), communion (i.e., attitude toward the importance of intimacy with sex partner), and instrumentality (i.e., attitude regarding the enjoyment of sex; Hendrick et al., 2006). The scale used a 5-point Likert-type scale ranging from “strongly agree with statement” to “strongly disagree with statement.” Cronbach’s alpha levels were reported for each content item among the human sexuality domains over the course of three separate studies. Study 1 results ranged from acceptable to strong (permissiveness = .93, birth control = .84, communion = .71, instrumentality = .77). Study 2 results ranged from acceptable to strong (permissiveness = .95, birth control = .87, communion = .79, instrumentality = .80). Study 3 results ranged from unacceptable to strong (permissiveness = .92, birth control =
The Brief Sexual Attitudes Scale is the most appropriate for this study due to the fact that similar dissertations utilizing similar variables have reported reliable results (see Cupit, 2010; Hanzlik & Gaubatz, 2012).

The Ariffin et al. (2015) Sexual History Taking Scale was utilized to address the dependent variable in Research Questions 2 and 3. The scale is a 25-item, quantitative survey created to assess five domains (i.e., demographic information, awareness and understanding of taking a sexual history, actual practice of taking a sexual history, comfort and confidence in taking a sexual history, training and education around taking a sexual history). It is broken down into two subscales with a 5-item scale specifically assessing sexual topics and a 20-item scale assessing the aforementioned domains. A 5-point Likert-type scale was utilized ranging from “strongly disagree” to “strongly agree.” The scale was modified from the Ariffin et al. (2015) scale, which was created to measure the perceptions and attitudes of medical students concerning sexual history taking and training. Ariffin et al. (2015) reported a Cronbach’s alpha of 0.73. Comparatively, the modified scale used in Gregory and Paylo (2020) warranted a Cronbach’s alpha of 0.792. Given that 0.7 is considered an acceptable Cronbach’s alpha (Tavakol & Dennick, 2011), the modified questionnaire was utilized in the current study and the same analyses were used to check the psychometric properties to determine if this scale was in fact similar to what has been published in the literature.

Methods of Data Analysis

Methods of analysis that were utilized for this proposed study included 1) descriptive statistical analyses, 2) comparisons of various relationships using Pearson product moment correlation coefficients, and 3) running a simple linear regression as well as a multiple linear regression analysis. For the purpose of this research study, the simple linear regression was used
to assess Research Question 1, and a multiple linear regression was used to assess Research Question 2. Both are some of the most widely used statistical techniques for hypothesis testing and predicting values for dependent variables. The simple linear regression evaluated the relationship between one independent variable and one dependent variable (Zou, Tuncali, & Silverman, 2003). The multiple linear regression evaluated the relationship between two or more independent variables and one dependent variable (Freedman, 2004).

Descriptive Statistics

Descriptive statistics were analyzed using various participant demographic data. Additionally, means and standard deviations for these data and for the scales, scores, and sub-scores were composed and analyzed. Descriptive statistics were analyzed through both categorical and numeral quantifications to determine any relationships between the participants’ information given and their subsequential scores on their completed survey as well as the skewness and kurtosis associated with the dependent variable(s).

Pearson Correlations

Pearson correlations were analyzed for all scales and subscales: the Behun et al. (2017) Sexual Training Scale, the Harris and Hays (2008) Comfort and Willingness Scale, the Hendrick et al. (2006) Brief Sexual Attitudes Scale, and the Ariffin et al. (2015) Sexual History Taking scale. A priori G*Power was completed for bivariate correlations. The sets of scores are independent data, which are measured through ratio scaling through the usage of Likert scales. The relationship between scores was analyzed through score comparisons with Pearson coefficients representing the negative or positive correlations found between dependent and independent variables.
Regression Analysis

To further determine any impact of the relationship between scores on the Behun et al. (2017) Sexual Training Scale, the Harris and Hays (2008) Comfort and Willingness Scale, the Hendrick et al. (2006) Brief Sexual Attitudes Scale, and the Ariffin et al. (2015) Sexual History Taking Scale, regression analysis was utilized. According to Altman and Krzywinski (2015), “In simple regression, there is one independent variable, \( X \), and one dependent variable, \( Y \)” (p. 999).

To reiterate, a simple linear regression analysis was used to assess Research Question 1 (R1: What is the relationship between college counselors’ sexuality education and the probability they will take a client’s sexual history?). Again, a multiple linear regression was used to assess Research Question 2 (R2: What is the relationship between college counselors’ comfort level, willingness, and attitudes regarding sex-based therapeutic conversations with clients and the probability they will take a client’s sexual history?). According to Nishishiba et al. (2014), a multiple regression analysis is defined as “a regression analysis performed when there is more than one independent variable in the regression analysis” (p. 349).

Demographic Statistics

Demographic statistics were collected using a typical participant demographic questionnaire assessing age, gender expression, major, race, ethnicity, and other common demographic variables. Furthermore, analysis was conducted to assess how all demographic factors relate to the variables. The information was collected in order to report whether the sample represents the population.

Limitations

As with any research survey design, the possibility of false reporting exists. There are a number of reasons why participants may not accurately respond to surveys, including social
desirability bias and memory recall inaccuracies. Also due to what some believe to be a sensitive
topic (i.e., sex) and the confidentiality of clients, some counselors might have chosen not to
answer questions honestly. Similarly, more sexually conservative college counselors may have
chosen not to participate at all due to possible discomfort with the topic. It is also quite likely
that said counselors who are uncomfortable discussing sexual issues with their clients would be
less likely to complete a sexual history, thereby making the absence of their data a major
limitation to the overall findings. Finally, another limitation of this study is that results are
considered correlational, and therefore results are unable to show cause and effect.

Validity

There are a number of threats that did not apply to this study base on the research design.
Since the survey that was distributed was a one-time survey and not taken multiple times (e.g.,
pre- and posttest), history threats and testing threats did not apply. Also given that my sample
was a one-group design, selection threat and mortality were not applicable for this particular
study. Given that the sample was randomly chosen based on voluntary participation, this
research therefore was enhanced and further validated the generalizability of this study
(Creswell, 2014). With that being said, there was still a minor possibility to the threat of
regression if the individuals who participated in the research were not representative of the actual
population (e.g., counselors who belong to the national counseling association may be in an
upper quadrant of the population base). There was also the threat of short-term maturation due to
the fact that there is no way of controlling the participants’ situational affects (e.g., tiredness,
boredom, hunger, inattention, etc.). Finally, as with any self-reporting research, there was a
possibly of a desirability bias.
CHAPTER 4: RESULTS

In this chapter, I present results of the data gathered from 83 voluntarily participants, all of whom met the criteria for the study (i.e., licensed mental health professionals working at accredited university or college counseling centers within the United States). This chapter will detail the demographic information, a descriptive statistical analysis, and comparisons of various relationships using Pearson product moment correlation coefficients and provide results for the two remaining hypotheses/research questions through a simple linear regression and a multiple linear regression analysis. As a reminder, the purpose of this study was to explore the relationship between human sexuality education/training of mental health professionals working in college counseling centers. Specific variables included human sexuality education/training as well as comfort levels, willingness, and attitudes of mental health professionals working in college counseling centers when communicating with clients about sex and human sexuality. Finally, this study also explored the relationship between the variables and the probability of mental health professionals working in college counseling centers to take a sexual history from clients.

Data Gathering

Voluntary participants’ responses were recorded over a six-week period between April 28, 2021, and June 8, 2021. During this period, 83 complete and recorded responses were received, and 42 responses were in progress (surveys started but not completed or submitted). Using the program G*Power, a minimum of 55 participants for $H_1$ and 77 participants for $H_2$ were required for a priori research planning with alpha < .05, a moderate effect size, and power $\geq .80$. The data analysis below includes only the N = 83 complete and recorded responses.
The primary recruitment for participation was through a professional organization listserv (i.e., American College Counseling Association [ACCA]). I was able to utilize this listserv via membership of the ACCA. Data were collected via Qualtrics, an online survey creation and administration program. A total of three emails containing the Qualtrics link to the survey were sent to the ACCA listserv requesting voluntary participation of licensed mental health professionals working at accredited university or college counseling centers within the United States.

**General Characteristics**

The sample consisted of 83 licensed college counseling professionals who reported to be working at accredited university or college counseling centers within the United States. With regards to gender, the respondents were provided three gender identities from which they could choose (i.e., male, female, and not listed). The option “not listed” was also accompanied by an open field to fill in the gender identifier that best described their gender identity. These descriptive statistics resulted in n=67, 80.7% female, n=15; 18.1% male; and n=1, 1.2% not listed (Table 1). These results are closely representative of the overall demographics of college counseling centers throughout the United States. Statistics from a research project entitled *A Survey of Demographic, Professional, and Clinical Characteristics of Clinicians in University Counseling Centers* (Newhart, Pohto, & Mullen, 2021) found that 75.1% of college counseling clinicians identified as female, 23.4% identified as male, and 0.5% preferred not to disclose their gender identity. Also given that research has shown that individuals who identify as female are more apt to voluntarily participate when compared to individuals who present as male (Mulder & Bruijne, 2019; Smith, 2008), it is likely that the current research is representative of the overall population of college counseling clinicians on the basis of gender.
Table 1. Gender

<table>
<thead>
<tr>
<th>Variables</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n)</td>
<td>(%)</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>67</td>
<td>80.7</td>
</tr>
<tr>
<td>Male</td>
<td>15</td>
<td>18.1</td>
</tr>
<tr>
<td>Nonbinary</td>
<td>1</td>
<td>1.2</td>
</tr>
</tbody>
</table>

With regard to age, the respondents were provided an open field to fill in their current age. The age ranged from 24 to 68, with the mean age being 39.9 years. According to an article entitled “College Counselor Demographics and Statistics in the US” (2021), the average age of U.S.-based college counselor clinicians is 41.1. When it comes to age, the mean age of the current research is only about 1.2 years different from the U.S. average and therefore seems to be representative of the overall population of college counseling clinicians.

With regard to race, participants were provided nine primary racial identity choices, including “not listed,” which was also accompanied by an open field to fill in the racial identity that best described their racial identity. These descriptive statistics resulted in n=69, 83.1% White or Caucasian; n=7, 8.4% Black or African American; n=3, 3.6% Asian or Indian; n=2, 2.4% Hispanic or Latino; and n=2, 2.4% multiracial (Table 2). According to the aforementioned study by Newhart et al. (2021), college counseling clinicians who participated identified as follows: 81.0% White, 8.3% Black or African American, 2.9% Asian, 2.4% Hispanic or Latino, 2.4% multiracial, and 3.0% other. The current sample also seems to be representative of the overall population of college counseling clinicians on the basis of race.
Table 2. Race

<table>
<thead>
<tr>
<th>Variables</th>
<th>Frequency (n)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White/Caucasian</td>
<td>69</td>
<td>83.1</td>
</tr>
<tr>
<td>Black/African American</td>
<td>7</td>
<td>8.4</td>
</tr>
<tr>
<td>Asian/Indian</td>
<td>3</td>
<td>3.6</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>2</td>
<td>2.4</td>
</tr>
<tr>
<td>Multiracial</td>
<td>2</td>
<td>2.4</td>
</tr>
</tbody>
</table>

Professional Experiences

Questions in the demographics section also assessed for years of experience. For this survey, professional counseling experience was collected as categorical data, with five different levels. The majority of the college counseling professionals fell between 0-5 years of experience (n=40, 48.2% had 0-5 years of experience; n=19, 22.9% had 6-10 years of experience; n=11, 13.3% had 11-15 years of experience; n=7, 8.4% had 16-20 years of experience; and n=6, 7.2% had 20+ years of experience; Table 3). Researchers Newhart et al. (2021) did not utilize categorical data but found that the average overall counseling experience was 13.6 years, and the average years of counseling experience within a college counseling center was 9.2 years. This research found that over 70% of participants had 10 years or less professional counseling experience and nearly 85% had under 15 years, making the current sample on par with findings of other studies focused on college counseling.

Table 3. Years of Experience

<table>
<thead>
<tr>
<th>Variables</th>
<th>Frequency (n)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 Years</td>
<td>40</td>
<td>48.2</td>
</tr>
<tr>
<td>6-10 Years</td>
<td>19</td>
<td>22.9</td>
</tr>
<tr>
<td>11-15 Years</td>
<td>7</td>
<td>8.4</td>
</tr>
<tr>
<td>16-20 Years</td>
<td>6</td>
<td>7.2</td>
</tr>
<tr>
<td>20+ Years</td>
<td>6</td>
<td>7.2</td>
</tr>
</tbody>
</table>
The majority of the participants worked as full-time college counseling clinicians (n=72, 86.7% full time), a small minority reported working part time as a college counseling clinician (n=9, 10.8% part time), and a few reported “other” employment status (n=2, 2.4% other). This was surprisingly similar to Newhart et al. (2021) when researching demographic, professional, and clinical characteristics of clinicians in university counseling centers. The researchers reported that participants were 86.8% full time, 10.7% part time, and 1.5% other employment arrangements.

Table 4. Employment Status

<table>
<thead>
<tr>
<th>Variables</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full time</td>
<td>72</td>
<td>86.7</td>
</tr>
<tr>
<td>Part time</td>
<td>9</td>
<td>10.8</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>2.4</td>
</tr>
</tbody>
</table>

In regard to education, participants were provided five choices, including “not listed,” which was also accompanied by an open field to fill in their particular educational background. Participants in this study reported their highest level of education to be n=46, 55.4% master’s degree; n=28, 33.7% doctoral degree; n=6, 7.2% Ph.D./doctoral candidate; and n=3, 3.6% other (i.e., one psychiatrist and two education specialists; Table 5). This was also similar to Newhart et al. (2021), who reported their participants’ highest level to be a master’s degree (56.1%), followed by a doctoral degree (41.5%) and 1.5% reporting other. The current study also found the sample participants’ licensures to be n=42, 50.6% counseling; n=24, 28.9% psychologist; n=13, 15.7% social worker; n=2, 2.4% marriage and family therapist; n=1, 1.2% psychiatrist; and n=8, 9.6% other (Table 5). After reviewing a number of the descriptive statistics, one could conclude that the current research study appears to be representative of the overall population.
Table 5. **Education and Licensure**

<table>
<thead>
<tr>
<th>Variables</th>
<th>Frequency (n)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Master’s Degree</td>
<td>46</td>
<td>55.4</td>
</tr>
<tr>
<td>Doctoral Degree</td>
<td>28</td>
<td>33.7</td>
</tr>
<tr>
<td>Doctoral Candidate</td>
<td>6</td>
<td>7.2</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>3.6</td>
</tr>
<tr>
<td><strong>Licensure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counselor</td>
<td>42</td>
<td>50.6</td>
</tr>
<tr>
<td>Psychology</td>
<td>24</td>
<td>28.9</td>
</tr>
<tr>
<td>Social Work</td>
<td>13</td>
<td>15.7</td>
</tr>
<tr>
<td>Marriage and Family Therapy</td>
<td>2</td>
<td>2.4</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
<td>9.6</td>
</tr>
</tbody>
</table>

**Human Sexuality Education and Training**

Human sexuality education and training is an important element and vital variable in this research. The aforementioned Professional School Counselors’ Perceptions of Preparedness to Counsel Students on Human Sexuality Scale (Behun et al., 2017) was utilized to fully assess participants’ human sexuality and training. In addition, two questions in the demographics asked specific pointed questions assessing the participants’ direct education and training in regard to human sexuality. When asked directly if the participants had taken a human sexuality class, n=31, 37.3%, reported that human sexuality was not a primary focus in a single course but it was incorporated into other classes; n=20, 24.1%, reported no, there was no content related to human sexuality in my program; n=19, 22.9%, reported yes, it was an elective; and n=13, 15.7%, reported that it was required. In total, this results in 38.6% having taken a course directly related to human sexuality and 61.4% having never taken a course directly related to human sexuality (Table 6).
Table 6. Human Sexuality and Training

<table>
<thead>
<tr>
<th>Variables</th>
<th>Frequency (n)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Direct Human Sexuality Education and Training</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not a primary focus in a single course; incorporated into other classes</td>
<td>31</td>
<td>37.3</td>
</tr>
<tr>
<td>There was no content related to human sexuality in my program</td>
<td>20</td>
<td>24.1</td>
</tr>
<tr>
<td>It was an elective</td>
<td>19</td>
<td>22.9</td>
</tr>
<tr>
<td>It was required</td>
<td>13</td>
<td>15.7</td>
</tr>
<tr>
<td><strong>What education or training has best prepared you for counseling students regarding issues related to human sexuality</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional Training</td>
<td>48</td>
<td>57.8</td>
</tr>
<tr>
<td>Graduate Course in Human Sexuality</td>
<td>13</td>
<td>15.7</td>
</tr>
<tr>
<td>Graduate Course in Multicultural Counseling</td>
<td>6</td>
<td>7.2</td>
</tr>
<tr>
<td>Graduate course in human growth and development or lifespan counseling</td>
<td>4</td>
<td>4.8</td>
</tr>
<tr>
<td>Another course not listed</td>
<td>5</td>
<td>6.0</td>
</tr>
<tr>
<td>Nothing</td>
<td>7</td>
<td>8.4</td>
</tr>
</tbody>
</table>

Furthermore, when participants were asked what education or training had best prepared them for counseling students regarding issues related to human sexuality, n=48, 57.8%, reported additional training (e.g., continuing education, workshops, in-services); n=13, 15.7%, reported a graduate course in human sexuality; n=6, 7.2%, reported a graduate course in multicultural counseling; n=4, 4.8%, reported a graduate course in human growth and development or lifespan counseling; n=5, 6.0%, reported another course not listed; and n=7, 8.4%, reported nothing had prepared them for counseling clients on issues related to human sexuality. In total, these results indicate that 33.7% of participants felt as though their graduate programs had best prepared them for counseling clients on issues related to human sexuality.

**Providing Human Sexuality Counseling**

Finally, there were three questions at the end of the demographics section that assessed participants’ experiences providing human sexuality counseling to clientele. When the participants were asked if they had ever provided human sexuality counseling to clients, n=83,
100%, reported yes, they had provided counseling to clients that related to human sexuality or sexual issues (Table 7). When asked if participants believed it was the responsibility of the counselor to provide counseling to clients regarding issues related to human sexuality and sexual issues, n=78, 94.0% reported yes; n=5, 6.0% reported they were unsure; and n=0, 0.0%, reported no. Lastly, when asked to what extent participants agreed with the statement, “I only assess and initiate conversations on sexuality-related issues when the client states that it is a concern,” n=7, 8.4%, reported that they strongly agreed; n=31, 37.3%, reported that they agreed; n=14, 16.9%, reported that they neither agreed nor disagreed; n2=7, 32.5%, reported they disagreed; and n=4, 4.8%, reported that they strongly disagreed (Table 7). In total, this resulted in 37.3% of respondents who reported that they assessed and initiated conversations with clients regarding sexuality, and 37.3% only assessed and initiated conversations on sexuality-related issues after a client brought up said topic.

Table 7. Human Sexuality Counseling

<table>
<thead>
<tr>
<th>Variables</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ever provided human sexuality counseling to clients</td>
<td>n</td>
<td>(n)</td>
</tr>
<tr>
<td>Yes</td>
<td>83</td>
<td>100.0</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Responsibility of the counselor to provide counseling to clients regarding issues related to human sexuality and sexual issues?</td>
<td>n</td>
<td>(n)</td>
</tr>
<tr>
<td>Yes</td>
<td>78</td>
<td>94.0</td>
</tr>
<tr>
<td>Unsure</td>
<td>5</td>
<td>6.0</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Overview of Scores from Instrumentation

A total of four scales were utilized for this research. Behun et al.’s (2017) Professional School Counselors’ Perceptions of Preparedness to Counsel Students on Human Sexuality Scale was utilized to assess participants’ human sexuality education and training levels. The Harris and
Hays (2008) Comfort and Willingness Scale was utilized to assess both the participants’ comfort and willingness levels when discussing sexual topics with their clients. The Hendrick et al. (2006) Brief Sexual Attitudes Scale was utilized to assess the participants’ attitudes regarding sex. Finally, the Ariffin et al. (2015) Sexual History Taking Scale was utilized to assess the participants’ actual practices of taking a sexual history.

Results shown in Table 8 indicated that participants reported relatively high overall comfort having sex-based communication with clients, M= 4.10. These results also indicate that participants reported an above average overall sexual attitude level, M= 3.74. Similarly, results indicated that participants reported an above average overall sexual history taking level, M= 3.47. Finally, results indicate that participants reported slightly above average human sexuality education and training levels as well as willingness levels, M= 3.34 and 3.20 respectively. When comparing data using means, standard deviations, sample size, skewness, and kurtosis, these data indicate an overall normal distribution. Conditions helping to view these data include exceeding the G*Power minimum of 77 participants (i.e., as mentioned in Chapter 3 for each hypothesis) and having skewness and kurtosis falling within +2.00 and -2.00 (Creswell, 2014).

Table 8. Instrumentation

<table>
<thead>
<tr>
<th>Variables</th>
<th>N Statistic</th>
<th>Range Statistic</th>
<th>Minimum Statistic</th>
<th>Maximum Statistic</th>
<th>Mean Statistic</th>
<th>Std. Deviation Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combined Human Sexuality Education and Training</td>
<td>83</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>3.34</td>
<td>.806</td>
</tr>
<tr>
<td>Combined Comfort</td>
<td>83</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>4.10</td>
<td>.504</td>
</tr>
<tr>
<td>Combined Willingness</td>
<td>83</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>3.20</td>
<td>.701</td>
</tr>
<tr>
<td>Combined Attitude</td>
<td>83</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>3.74</td>
<td>.342</td>
</tr>
<tr>
<td>Combine Sexual History</td>
<td>83</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>3.47</td>
<td>.416</td>
</tr>
<tr>
<td>Valid N</td>
<td>83</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Descriptive Statistics of the Human Sexuality Education and Training Scale

Behun et al. (2017) Professional Counselors’ Perceptions of Preparedness to Counsel Students on Human Sexuality Scale participants reports were analyzed. The cumulative report for human sexuality education and training included $M=3.34$ and $SD=0.806$ out of a 5-point Likert scale (see Table 8). These results indicate that overall, the participants somewhat agreed that their human sexuality education and training fully prepared them to have sex-based communication with their clients. Specifically, 7.07% strongly disagreed, 21.12% disagreed, 16.06% neither disagreed nor agreed, 42% agreed, and 13.73% strongly agreed. This means that overall, about 56% of the participants agreed to some degree that their human sexuality education and training prepared them to have sex-based communication with their clients. This also means that about 28% of the participants disagreed to some extent that their human sexuality education and training prepared them to have sex-based communication with their clients.

When asked directly if participants had ever completed a human sexuality course, 12.7% reported yes and that it was required, 18.6% reported yes and that it was an elective, 30.4% reported that human sexuality was not a primary focus in any single course (although it was incorporated into other classes), and 19.6% reported no and that there was no content related to human sexuality in their programs. Furthermore, when asked what education or training had best prepared them for counseling students regarding issues related to human sexuality, 3.9% reported it was a human growth/lifespan graduate course, 5.9% reported it was a multicultural graduate course, 12.7% reported it was a human sexuality graduate course, and 4.9% reported it was another course that was not listed. Overall, 27.4% of the participants reported that their program’s course work best prepared them for counseling students regarding issues related to
human sexuality. Furthermore, 47.1% reported that additional trainings (e.g., continuing education, workshops, in-services, etc.) prepared them for counseling students regarding issues related to human sexuality. Finally, 4.9% reported that nothing had prepared them for counseling students regarding issues related to human sexuality.

**Descriptive Statistics of the Comfort Scale**

The Harris and Hays (2008) Comfort and Willingness Scale assessed how comfortable and willing a mental health clinician would be when discussing sexual topics with their clients as well as their willingness to engage in sexual-related topics with clients. This scale was split into two sections (i.e., comfort being one subscale and willingness being the other). The cumulative report for comfort levels included $M=4.10$ and $SD=0.504$ out of a 5-point Likert scale (see Table 8). This means on average participants reported moderate to extreme comfort levels when discussing sexual topics with their clients as well as their willingness to engage in sexual-related topics with clients. This subscale was broken down even further into two separate subscales (i.e., comfort discussing sex with specific clients and groups and comfort discussing different sexual topics).

To recap, when looking at the subscale regarding comfort discussing sex with specific clients and groups overall, 42.1% reported they were extremely comfortable, 40.2% reported they were moderately comfortable, 9.9% reported they were neither comfortable nor uncomfortable, 6.3% reported they were moderately uncomfortable, and 1.4% reported they were extremely uncomfortable. This indicates that 82.3% of participants reported some level of comfort and 7.7% reported some level of discomfort when discussing sex with specific clients and groups. The highest rated comfort levels were reported for female clients (77.5% comfort and 3.9% discomfort), student clients or trainees (75.5% comfort and 3.9% discomfort), male
clients (74.6% comfort and 6.9% discomfort), and relationship counseling (74.5% comfort and 1% discomfort). The lowest comfort levels were reported for preteen clients (47% comfort and 18.6% discomfort), teen clients (67.6% comfort and 13.7% discomfort), and mentally disabled clients (53.9% comfort and 11.8% discomfort). When looking at the subscale regarding comfort assessing different ways in which they communicated about sex (e.g., I respond openly and confidently when my sexual values are challenged; I communicate effectively about human sexuality; I appear poised in sessions when addressing sexual matters, etc.), 34.7% strongly agreed, 38.9% moderately agreed, 21.3% neither agreed nor disagreed, 2.3% moderately disagreed, and 2.8% strongly disagreed. This indicates that 73.6% of participants reported some level of comfort and 5.1% reported some level of discomfort when communicating with clients about sex.

**Descriptive Statistics of the Willingness Scale**

Again, the Harris and Hays (2008) Comfort and Willingness Scale assessed participants ‘willingness to engage in sexual-related topics with clients. The cumulative report for willingness levels included M= 3.20 and SD= .701 out of a 5-point Likert scale (see Table 8). This indicates that the participants reported that they were fairly willing to engage in sexual-related topics with clients. Specifically, when participants were asked the frequency to which they were willing to assess for particular sex-related topics, 20.0% reported they were always willing, 22.8% reported they most of the time were willing, 17.1% reported that half the time they were willing, 40.5% reported sometimes they were willing, and 0.00% reported that they were never willing. The highest rated willingness levels were reported for client’s body satisfaction, with 73.5% of participants reporting that they always assess or assess most of the time; nonconsensual sex as victim, with 69.9% of participants reporting that they always assess
or assess most of the time; and sexual orientation, with 67.5% of participants reporting that they always assess or assess most of the time. The lowest willingness levels were reported for contraception, with 24.1% of participants reporting that they always assess or assess most of the time; sexual dysfunction, with 25.3% of participants reporting that they always assess or assess most of the time; sexual relationship enhancement, with 27.7% of participants reporting that they always assess or assess most of the time; and sexually transmitted diseases/infections, with 28.9% of participants reporting that they always assess or assess most of the time.

**Descriptive Statistics of the Attitude Scale**

The Hendrick et al. (2006) Brief Sexual Attitudes Scale was utilized to assess the survey takers’ attitudes toward human sexuality. The cumulative report for attitudes levels included $M=3.74$ and $SD=.342$ out of a 5-point Likert scale (see Table 8). This means on average participants reported positive attitudes toward different sex-based opinions and topics, meaning they mostly agreed with open-minded and affirming statements. Specifically, when participants were asked to rate how strongly they agree or disagree with a number of open-minded sex-based opinions and topics, 33.4% strongly agreed, 21.6% moderately agreed, 30.2% neither agreed nor disagreed, 14.8% moderately disagreed, and 0.00% strongly disagreed. The highest rated attitude levels were reported for men’s responsibility for birth control, with 91.6% agreeing to some extent; women’s responsibility for birth control, with 88.0% agreeing to some extent; birth control is a part of responsible sexuality, with 89.2% agreeing to some extent; and one does not need to be committed to a person to have sex with them, with 89.2% agreeing to some extent. The lowest rated attitude levels were reported where that sex is primarily physical, with 41.0% moderately disagreeing and 41.0% neither agreeing or disagreeing, and for sex is primarily a
bodily function, like eating, with 28.8% moderately disagreeing and 39.8% neither agreeing nor disagreeing.

**Descriptive Statistics of the Sexual History Scale**

The Ariffin et al. (2015) Sexual History Taking Scale was utilized to assess the mental health clinician’s overall probability to complete a sexual history with clients. The cumulative report for sexual history taking resulted with \( M = 3.47 \) and \( SD = .416 \) out of a 5-point Likert scale (see Table 8). These results indicate that overall, the participants scored above average, meaning that they were slightly more likely to complete a sexual history. This scale was split into two subscales (i.e., probability to take a sexual history and frequency of taking a sexual history).

In the subscale that assessed the probability to take a sexual history (e.g., “I feel comfortable discussing sexual history with clients during an intake or initial session,” and “I believe it is important for counselors to take a sexual history during an intake or initial session”), participants chose to what level they agreed or disagreed with these statements. When rating these statements, 16.9% strongly agreed, 34.4% agreed, 27.2% neither agreed nor disagreed, 13.7% disagreed, and 7.8% strongly disagreed. The highest rate to which people agreed with the statements provided was 91.6% of participants agreed to some level that they feel comfortable asking clients about their sexual orientation, 90.4% agreed to some degree that they believe it is important for counselors to know how to take a sexual history during an intake or initial session, 88.0% agreed to some degree that they have thought about how their own attitudes, beliefs, and values may affect their questions regarding the sexual history taking with clients, and 86.7% agreed to some degree that they have the adequate skills to put a client at ease when discussing their sexual history during an intake or initial session. The lowest rating to which people agreed with the statements provided was 71.1% disagreed to some extent that they were taught during
training as a counselor that it is important to take a client’s sexual history during an intake or initial session, and 61.4% disagreed to some extent that they believed they take a thorough sexual history of clients. Furthermore, only 16.8% agreed that they believed they take a thorough sexual history of clients. There were also two very interesting results from this particular subscale. When asked if participants believed that there was not enough counseling training on how to discuss sexual history with clients, 55.4% reported that they neither agreed nor disagreed, 43.4% strongly disagreed, and 1.2% strongly agreed. And finally, when asked if participants believed they have limitations when asking questions regarding a client’s sexual history during an intake or initial session, 94.0% reported they neither agreed nor disagreed and 6.0% strongly disagreed.

When looking at the subscale regarding sexual history taking frequency, 26.5% reported frequently, 32.5% reported moderately frequently, 24.5% reported neither frequently or nonfrequent, 16.4% reported nonfrequent, and 0.0% reported nonfrequent. The prompts to which the participants reported the highest frequency was client’s sexual identity and sexual violence history, with 79.5% and 78.3% reporting some level of frequency, respectively. The prompt to which the participants reported the lowest frequency was client’s sexual health with 28.9% reporting that it is moderately nonfrequent for them to question this topic during sexual history taking.

**Reliability Analyses for Instruments**

In accordance with best practices, a Cronbach’s alpha was run on all four of the scales that were used for this research. Running and reporting the score reliability for these scales will allow fellow researchers to compare the results of this research to other studies using these scales or scales of related constructs (Creswell, 2014). The score reliability was analyzed in this
research to further understand the internal consistency of the data. The Behun et al. (2017) scale, which was used to measure the reported human sexuality education and training, resulted in a Cronbach’s alpha of .94, meaning the scale resulted in extremely strong score reliability. The original publication of this scale reported Cronbach’s alpha ranging from .87 to .92. The Harris and Hays (2008) scale, which was used to measure sexual comfort and willingness during communication, resulted in a Cronbach’s alpha of .93 for the comfort subscale and .91 for the willingness subscale. Both of these scores indicate extremely strong score reliability. In the original publication, Harris and Hays (2008) reported a combined Cronbach’s alpha of α = 0.86. Hendrick et al.’s (2006) Brief Sexual Attitudes Scale resulted in a Cronbach’s alpha of .74. This score indicates a more moderate score reliability. The original study showed results with the Cronbach’s alpha ranging from .71 to .93. Finally, the Ariffin et al. (2015) Sexual History Taking Scale resulted in a Cronbach’s alpha of .83. This score indicates a strong score reliability. Ariffin et al. (2015) reported a Cronbach’s alpha of .73. Comparatively, the modified scale used in Gregory and Paylo (2020) warranted a Cronbach’s alpha of .79, for the purposes of this exploratory study, these scores are exceedingly satisfactory, indicating that the items in these scales were consistent and related to one another.

**Hypothesis 1**

Hypothesis 1 stated that mental health professionals working in college counseling centers who report higher levels of human sexuality education and training will report a stronger probability to take a sexual history from clients. A simple linear regression was conducted to test Hypothesis 1 (Table 9). Hypothesis 1 was tested using two variables, with variable 1 being total reported human sexuality education and training levels and variable 2 being total reported sexual history taking levels. Data from Hypothesis 1 revealed that there was a small statistically
significant correlation between these two variables ($r = .294; p=.007$). Mental health professionals working in university or college counseling centers reported human sexuality education and training is expected to be related to their total reported sexual history taking levels. The adjusted $R^2$ value in this data set was .075, meaning that 7.5% of the variance in the variable sexual history taking (i.e., the dependent variable) can be explained by having human sexuality education and training (i.e., the predictor or independent variable) in the regression model.

Further analysis showed no outliers, with standardized residuals being between -3.29 and 3.29. The standardized residuals here were -2.64 and 2.43. When it came to independence of observation, an independence of errors was checked by utilizing a Durbin-Watson test. The Durbin-Watson should not be less than 1.00 or more than 2.00. This test produced a result of 1.14, meaning the assumption of independence of observations has also been met. Finally, when checking for normality, the P-P plot shows that the values generally line up along a 45-degree line. This breakdown can be seen below in Figures 1 and 2, and it suggests normality of residuals. Furthermore, the histogram (Figure 2) shows that the dependent variable of sexual history taking is also normally distributed.

Table 9: Linear Regression Results

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
<th>t</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Constant)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>B: 2.949</td>
<td>Std. Error: .188</td>
<td>Beta: .294</td>
<td>15.646</td>
</tr>
<tr>
<td>Education/Training</td>
<td>.152</td>
<td>.055</td>
<td>.294</td>
<td>2.766</td>
</tr>
</tbody>
</table>
Figure 1. Hypothesis 1 plot distribution.

Figure 2: Hypothesis 1 histogram.
**Hypothesis 2**

Hypothesis 2 stated that mental health professionals working in college counseling centers who report higher comfort, willingness, and attitude levels when communicating with clients about sex and human sexuality will report a stronger probability to take a sexual history from clients. A multiple linear regression model was conducted to test Hypothesis 2 (Table 10). Hypothesis 2 was tested using a total of four variables, with the independent variables (i.e., predictors) being total reported comfort, willingness, and attitude levels when communicating with clients about sex and human sexuality and the dependent variable being total reported sexual history taking levels. Data from Hypothesis 2 revealed that there were statistically significant correlations between the independent and dependent variables ($p=.001$). The adjusted $R^2$ value for the regression model was .278, which indicates that 27.8% of the variance in the sexual history taking was explained by comfort, willingness, and attitude levels in the model.

Further analysis indicated no outliers, with standardized residuals being between -3.29 and 3.29. The standardized residuals here were -2.64 and 2.43. When it came to independence of observation, an independence of errors was checked by utilizing a Durbin-Watson test. The Durban-Watson should not be less than 1.00 or more than 2.00. Said test produced a result of 1.14, meaning the assumption of independence of observations has also been met. Finally, when checking for normality, the P-P plot shows that the values generally line up along a 45-degree line. These results can be seen below in Figures 3 and 4, and it suggests normality of residuals. Furthermore, the histogram (Figure 4) shows that the dependent variable of sexual history taking is also normally distributed.
Figure 3. Hypothesis 2 plot distribution.

Figure 4: Hypothesis 2 histogram.
The standard of error was .354, which indicates that there was about one-third of a Likert scale point of error in the model based on the dependent variable’s scale ranging from 1 to 5 points. The multiple regression result indicates that we can predict sexual history taking (i.e., account for a large proportion of the variance in this outcome variable) via the presence of two of the aforementioned predictors in the model. That is, when looking at the independent variables separately, we find that both comfort and willingness were predictors of sexual history taking ($p = .001, t = 4.548$; and $p = .024, t = 2.306$, respectively) and that attitudes was not a predictor ($p = .803; t = -.251$). As one can see from Table 9, comfort level was the most potent predictor of the outcome variable with a $t$-value$= 4.548$ and it also accounted for 18.2% of the variance in the dependent variable. Willingness had a $t$-value$= 2.306$ and accounted for 4.7% of the variance in the dependent variable.

As indicated in Table 10, it is clear that comfort was the dominant predictor in the regression model. Comfort was a statistically significant predictor of sexual history taking, which indicated that for every one unit increase in comfort, the sexual history taking increased by .373 scale points. When referring to the variables of the study, this means that for every scale point increase in comfort, the probability of a college counselor to take a sexual history from their client would also increase by .373 of a scale point. Although this is not a large statistical effect, when working with a 5-point scale, one could witness a potentially moderate practical effect. This means that by increasing the comfort levels of college mental health professionals to have sex-based therapeutic conversations with clients, we could potentially see a reasonable increase in the same individuals taking a sexual history from their clients.
Table 10: Multiple Linear Regression Results

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
<th>t</th>
<th>Sig</th>
<th>Correlations</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>Std. Error</td>
<td>Beta</td>
<td></td>
<td>Zero-order</td>
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<tr>
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<td>.479</td>
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<td>.001</td>
<td>.154</td>
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<tr>
<td>Attitudes</td>
<td>-.030</td>
<td>.121</td>
<td>-.025</td>
<td>-.251</td>
<td>.803</td>
</tr>
<tr>
<td>Willingness</td>
<td>.136</td>
<td>.059</td>
<td>.229</td>
<td>2.306</td>
<td>.024</td>
</tr>
<tr>
<td>Comfort</td>
<td>.373</td>
<td>.082</td>
<td>.452</td>
<td>4.548</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>
CHAPTER 5: OVERVIEW OF THE STUDY

In this final chapter, one will find an overview of this study, an overview of potential limitations, and a discussion of the results from Chapter 4. Implications and recommendations for counselors, counselor educators, and future researchers can also be found in this chapter. This study was designed to explore the relationships between a) human sexuality education and training and college counselors’ probability to take a sexual history as well as b) comfort, willingness, and attitude levels about sex and human sexuality and college counselors’ probability to take a sexual history. The results of this study were explored from two primary research questions, hypotheses, and analyses. The results can be found in the following sections.

Summary of Results

Results support the first hypothesis of this study, and in fact, there is a statistically significant relationship between human sexuality education and training and college counselors’ probability to take a sexual history. A simple linear regression was utilized to assess this relationship. Results from this study revealed that mental health professionals working in university or college counseling centers are slightly more likely to take a sexual history from their clients. The second hypothesis of this study was found to be true, that when run together in a multiple linear regression, comfort, willingness, and attitude levels about sex and human sexuality increase college counselors’ probability to take a sexual history. However, not all variables were predictive in the second hypothesis, with attitude levels not predicting a statistically significant relationship.
Discussion of Hypotheses

This study’s results provide support for both Hypotheses 1 and 2. The results of Hypotheses 1 and 2 are discussed in this section. The population and sample for both hypotheses were licensed mental health professionals working at accredited university or college counseling centers within the United States.

Hypothesis 1

The first hypothesis was that there will be a positive, statistically significant relationship between human sexuality education and training the clinicians’ probability to complete a sexual history. A simple linear regression was used to assess this relationship. Results from the regression indicate that there was a statistically significant positive relationship between human sexuality education and training and in the probability to complete a sexual history. The results of this study’s first hypothesis finding reflect that when licensed mental health professionals working at an accredited university or college counseling centers report higher levels of human sexuality and training, they are also more likely to report a probability to take a client’s sexual history. Even though this study’s explanation is relatively slight (i.e., only 7.5% of sexual history taking can be explained by human sexuality education and training), it is statistically significant. Implications about why and how increased human sexuality education and training increases the probability for licensed mental health professionals working at accredited university or college counseling centers to take a sexual history from clients are not the focus of this study.

Hypothesis 2

Hypothesis 2 proposed that there will be a positive, statistically significant relationship between comfort, willingness, and attitude levels when communicating with clients about sex and human sexuality and the clinicians’ probability to take a sexual history. A multiple linear
regression was used to assess this relationship. Results from the regression indicate that there was a statistically significant positive relationship between comfort and willingness levels when communicating with clients about sex and human sexuality and the clinicians’ probability to take a sexual history. The results of this study’s second hypothesis find reflect that when mental health professionals working in college counseling centers report higher levels of comfort, willingness, and attitude when communicating with clients about sex and human sexuality, they also report a stronger probability to take a sexual history from clients. This study showed that 27.8% of sexual history taking can be explained by comfort and willingness. When broken down individually, both comfort and willingness showed there was a positive statistically significant relationship, but adding attitude as a predictor did not show any positive statistically significant relationship. This will be discussed further in a later section of the discussion. Implications about why and how mental health professionals working in college counseling centers who report higher levels of comfort, willingness, and attitude levels when communicating with clients about sex and human sexuality also report a stronger probability to take a sexual history from clients were not the focus of this study.

**Discussion of Findings**

This study is one of the first studies to focus on college counselors’ self-reports regarding their sex-based communication with clients. This study was the first to assess sexual history taking probability within this population and in professional settings. More important is this study’s finding that both human sexuality education/training and the construct variable of comfort and willingness positively correlate with the probability that mental health clinicians will complete a sexual history with their clients. As previously stated in the literature review, one of the most essential ways to identify, treat, and promote sexual health is a thorough sexual
history taking by clinicians (Jones & Barton, 2004; Ribeiro et al., 2014). This study has provided
two different ways to increase the probability that mental health clinicians will complete a sexual
history with their clients.

The themes from this study include a) there may be a need for more human sexuality
education and training in the field of mental health, specifically with mental health professionals
working in college and university counseling centers, and b) there may be a need for mental
health professionals to increase their comfort and willingness to have sex-based communication
with clients, also specifically within the aforementioned settings. Higgins et al. (2012) found that
after a one-day workshop focused on interdisciplinary approaches to sexuality, healthcare
professionals reported increased levels of comfort with sexuality. With comfort being the
strongest statistically significant predictor in the present study of the participants' probability to
take a sexual history, one could argue that one way we can increase comfort within the
aforementioned construct variable is by providing more human sexuality and training options
and/or mandates. Given the above-mentioned findings by Higgins et al. (2012), it may be a two-
birds/one-stone scenario, meaning that mental health professionals can increase both their human
sexuality education/training and their comfort/willingness/attitude by seeking information on
human sexuality. These major themes present possible implications for mental health
professionals and the education systems in which they are educated and trained. Further
implications from this study’s major themes are continued below.

It is also important to address why the themes are worded as “there may be a need for
more human sexuality education and training” and not “there is a need.” This study found that
human sexuality education and training only accounted for 7.5% of the variance in the variable
sexual history taking that can be explained by having human sexuality education and training.
This is a very small accountability, meaning that even with an increase in human sexuality education and training, there may be very little change in the probability that a college counselor would take a sexual history. It is important to remember that only 38.6% have taken a course directly related to human sexuality, and 61.4% have never taken a course directly related to human sexuality. It is also important to remember that only 16.8% of participants in this study believed they take a thorough sexual history of clients, and only 71.1% feel they were taught how to take a client’s sexual history. Without further research, it is impossible to predict what impact human sexuality education and training would have on sexual history taking had more participants received more extensive education (i.e., an entire class dedicated to said subject). One could speculate that sexual history taking would increase if more college counselors were taught the importance of sexual history taking during their education and training. It is likely due to some of the prior research that has been conducted on other topics.

The basic idea behind what is about to be explained is that we do not know what we do not know. The academic term for this cognitive barrier is “the illusion of explanatory depth” (Alter, Oppenheimer, & Zemla, 2010; Mills & Keil, 2004; Rozenblit & Keil, 2002). It is possible that because many of the participants have never been formally taught the importance of a sexual history taking, openly discussing sex-related issues early in treatment, and assessing for sexual dysfunctions and issues, they do not realize how much information they are missing out on. It is possible that had more of the participants received a formal human sexuality education and training that the results may have shown education and training to be more of a valuable variable when it came to the probability of a college counselor taking a sexual history. The same could be said for comfort and willingness as well, even though said variables showed a stronger variance in this study.
Revisiting Social Learning Theory

Social learning theory (SLT) was discussed in Chapter 2 as an underlying cognitive process that could increase one’s probability to achieve a desired goal or expectation. The most simplistic way to describe SLT is observational learning. Observational learning, simply put, is when individuals observe others around them behaving in a variety of manners, and due to this exposure, the observers will imitate the models’ behaviors. If the observer's imitated behavior is rewarded and/or reinforced, the observer will likely continue said behavior. On the contrary, if the observer’s imitated behavior is not rewarded and/or reprimanded, the observer is less likely to continue the behavior. As described throughout this entire dissertation, as well as within the findings of this research, college counselors are not completing sexual histories with their clients.

Only 37.3% of respondents in this study reported that they assessed and initiated conversations with clients regarding sexuality. Further research may be needed to unequivocally state that the lack of human sexuality education and training hinders sexual history taking and sex-based communication of college counselors and their clients through an SLT lens. With that being said, it is possible to assume that if mental health professionals are not shown, trained, or educated to ask clients about sexual history or initiate these conversations, said mental health professionals may be less likely to complete a sexual history with their clients. Important data from this study that supports this theory is the fact that 16.8% of participants believed they take thorough sexual histories of clients, and 71.1% feel they were taught how to take a client’s sexual history.

Limitations

As with any study, this study did exhibit statistical and contextual limitations; it utilized quantitative data, which was unable to demonstrate a complete context of mental health
clinicians’ descriptions of their probability to take a sexual history (Creswell, 2014). This survey design method is not designed to capture all the contexts or reasons regarding college mental health clinicians’ probability to take a sexual history. The primary goal of this study was not to provide a comprehensive particularization but instead a broader generalization of macro-scale understanding. Furthermore, the goal is that the macro-scale findings may aid counselors, counselor educators, and supervisors in better understanding larger trends that relate to sexual history taking through statistical patterns. Finally, there is hope that this research will provide empirical evidence that will support further exploration regarding the topic of sexual history taking by professionals within the field of mental health.

A second potential limitation of this study includes that the participants were limited only to mental health professionals who were members of the American College Counseling Association (ACCA) and who opted into receiving emails via the association’s listserv. This sample of mental health professionals may have produced a skewed sample. Although the ACCA reports that they have over 1,400 members, this survey did not reach the entire population of college counselors and may have been targeting a particular subpopulation. Also, given that sex and human sexuality are still considered by some to be a sensitive topic, the individuals who were willing to complete an entire survey based on the said topic may already be more likely in general to have sex-based communication with clients. Because of this, there is a further possibility that this research could have possibly been collected from a skewed sample.

Another possible limitation is the current social climate of not only the United States but the social climate of the world. Before the study was sent out to participants, there was a very large national, if not international, gender-based movement. The impacts of the Me Too Movement (#MeToo), the TIME’S UP Movement, and the momentum of the Women’s Marches
continue to define and shape the social context of today’s society. Given the enormous impact these events and movements had on the nation, it would be erroneous to think that they did not affect many workplace environments. Given that the topic of this study focuses on sex-based communication between a mental health clinician and a client, it would not be surprising that the current social climate surrounding sex, abuse, and gender did not affect how some mental health professionals conduct their sessions. There was also another social climate and health emergency that is still affecting the lives of people around the world.

The proposal for this study began long before the phrase “COVID-19” existed. By the time the survey for this study was sent out to participants, we were in the middle of a global pandemic. How individuals conducted their work changed dramatically. Almost all higher education institutions were still conducting classes and almost all appointments virtually. University and college counseling centers were conducting most, if not all, sessions via telehealth. Websites and apps such as Zoom, Webex, and Google Meet became the norm for mental health session platforms. These platforms were instrumental in allowing mental health clinicians to continue their vitally important work while also eliminating the need for in-person sessions that helped slow the spread of this deadly virus. Even with all the benefits that telehealth brought to many workplaces, there were also inevitably limitations. One of these limitations includes the perception of impersonality. Many recent studies have found that while the many advantages outweighed the limitations, especially during a deadly global pandemic, telehealth providers and patients/clients reported feeling a less personal connection or rapport with one another (Connolly, et al., 2020; Gajarawala & Pelkowski, 2021; Gordon et al., 2020; Patel et al., 2021). Given that the data for this study was collected during a time when most college and university counseling centers were a year and a half into only conducting virtual telehealth
sessions, it is highly possible that the data collected could be vastly different from data that would have been collected before the global pandemic. Furthermore, given that the topic of this study focuses on sex-based communication between client and clinician, there may be an even stronger limitation that communication may have been hindered by virtual and telehealth platforms.

Another potential limitation is the experience reported by the participants. The current study’s results indicated that nearly 50% of the participants had under five years of experience. A recent study by researchers Newhart, Pohto, and Mullen (2021) on demographic, professional, and clinical characteristics of clinicians in university counseling centers found that the average overall counseling experience was 13.6 years. This means that the vast majority of this study’s participants are novice college counselors with a great deal less experience. It is possible that the lack of experience in university and college counseling could have affected the overall results of this study. There was also not an even distribution between the years of experience; therefore, I was unable to assess whether there were significant statistical differences between the novice and experienced college counselors.

Another interesting potential limitation is the Hendrick et al. (2006) Brief Sexual Attitudes Scale, which was used to measure sexual attitudes. The Cronbach’s alpha was found to be .737, the lowest measure of internal consistency of all of the scales utilized within this research. A Cronbach’s alpha of .737 has an internal consistency that is right at the threshold of being considered reliable. This means that this particular scale potentially may not be internally reliable. Being that attitude was the only predictor that was not found to be a statically significant predictor, it is possible that the scale itself did not measure what I was, in fact, trying to measure.
Studies mentioned in Chapter 2 found mixed results for this predictor, so it would be interesting and perhaps even advantageous for further research to utilize attitudes as a predictor.

There are many reasons why this scale did not produce the anticipated results. Further research would have to be conducted to empirically state the exact reasons, but there are several explanations that could point to the reasons this variable did not increase the probability that a college counselor would take a sexual history. One self-evident reason is the population that this scale was designed to study. All the other scales in this study utilized scales that were explicitly created to study clinicians. This scale did not have that specific qualifier. This scale was made to study the general population, which may have contributed to the fact that it did not produce the expected results. Another interesting fact is that the data collected to generate this scale is nearly 20 years old; it may be interesting to utilize an updated scale assessing attitudes toward sex and sexual norms. A lot has changed in the past two decades. What was considered taboo topics twenty years ago are potentially very different in today’s context and culture. This scale asked questions regarding casual sex, birth control responsibility, love versus physical pleasure, and many more issues that could be considered quite vanilla by today’s standards. This scale also does not consider sex that takes place outside of encounters between one male and one female. We know today it is not that simple, as we have individuals who do not identify within those binary terms. There are many more people who identify as LGBTQ+. There are people on the asexual spectrum who are not at all accounted for in this scale. There are also many more issues that would need to be assessed according to today’s standards regarding human sexuality, including but not limited to kinks/fetishes, polyamorous relationships, mobile applications that connect individuals for the purpose of casual sex, and open relationships.
Finally, another possible contextual limitation is the potential for skewed data due to the Hawthorne effect or social desirability bias (Nishishiba et al., 2014). It is also possible that even though the survey was anonymous, there is still potential for impression management in how participants answer the survey in a way that could regulate or alter results (Creswell, 2014). There is also the possibility that due to the length of the survey in its entirety or the desire to not answer in a particular way, participants may have also elected to answer “neutral” in any of the administered instruments due to all of them utilizing a 5-point Likert scale.

Validity

There are several threats that did not apply to this study based on the research design. Since the survey that was distributed was a one-time survey and was not taken multiple times, history threats and testing threats did not apply. Also, given that my sample was a one-group design, selection threat and mortality were not applicable for this particular study. Given that the sample was randomly chosen based on voluntary participation, this research, therefore, was enhanced and further validated the generalizability of this study (Creswell, 2014). With that being said, there was still a minor possibility to the threat of regression if the individuals who participated in the research were not representative of the actual population. There was also the threat of short-term maturation since there is no way of controlling the participants’ situational affect. Finally, as with any self-reporting research, there was a possibility of a desirability bias.

Implications for Mental Health Clinicians and Mental Health Educators

This study revealed that when university and college-based mental health clinicians report higher levels of human sexuality and education, they also report a higher probability to take a sexual history from their clients. This study also found that when university and college-
based mental health clinicians report higher levels of the construct variable comfort and willingness, they also report a higher probability to take a sexual history from their clients.

This study found that only 38.6% had taken a course directly related to human sexuality, and 61.4% had never taken a course directly related to human sexuality. Furthermore, this study found that only 33.7% of participants feel as though their graduate programs had best prepared them for counseling clients on issues related to human sexuality. Thankfully, participants also reported that 57.8% believed that additional training (e.g., continuing education, workshops, in-services) had best prepared them for counseling clients on issues related to human sexuality. And finally, 8.4% reported that nothing had prepared them for counseling clients on issues related to human sexuality. Even with the majority reporting that additional training had prepared them for counseling clients on issues related to human sexuality, this research shows there seems to be a lack of training and education happening in mental health education programs. Essentially this means that unless a mental health professional is willing to seek out human sexuality education and training during continuing education, workshops, and in-services, they likely receive little to none of this valuable information.

Other important findings from this study include the fact that 100% of the participants reported that they had provided counseling to clients that related to human sexuality or sexual issues. Furthermore, when asked if participants believed it was the responsibility of the counselor to provide counseling to clients regarding issues related to human sexuality and sexual issues, 0% reported no. It is clear that human sexuality is an essential part of one’s mental health and well-being (Laumann, Paik, & Rosen, 1999; Tobkin, 2010; Wincze & Weisberg, 2015), and given the information provided above, mental health clinicians need to know how to work with clients when these topics are presented in session. This study also found that only 37.3% of
participants reported that they assess and initiate conversations with clients regarding sex and human sexuality. It has been empirically proven that many patients and clients will not initiate communication regarding sexual matters with their healthcare providers, believing that if sexual issues were important, then the clinician would initiate that communication; furthermore, clinicians believe that if there were an issue or problem, patients or clients would initiate the topic (Abramsohn et al., 2013; Althof, Rosen, Perelman, & Rubio-Aurioles, 2013; Kingsberg, 2004; Lindau et al., 2012; Lindau et al., 2007; Marwick, 1999; Wimberly, Hogben, Moore-Ruffin, Moore, & Fry-Johnson, 2006). This study further shows that there is a pattern of silence around human sexuality communication within the field of university and college mental health centers.

**Recommendations**

This section will present various recommended interventions for mental health clinicians and mental health educators. Recommendations include both applicable and theoretical recommendations and academic and clinical interventions. Finally, recommendations for future mental health research are also presented in this section.

**Mental Health Clinicians in College or University Centers**

This section is focused on mental health clinicians working in college or university centers; this section will focus specifically on recommendations for such centers. As a mental health professional with experience working at multiple university counseling centers over the years, along with my study’s findings of a positive statistically significant relationship between human sexuality education and training and a clinician’s probability to complete a sexual history, I recommend various interventions best suited for mental health professionals. Interventions recommended based on my study are a) for mental health professionals working in university or
college counseling centers to seek out human sexuality education and training, b) for directors and supervisors at university or college counseling centers to incorporate human sexuality education and training into professional development, and c) for university and college counseling centers to incorporate sexual history taking into their intake procedures.

Addressing the recommendation that mental health professionals working in university or college counseling centers seek out human sexuality education and training, there are several reasons this recommendation is being made. Throughout the rest of this section, there will be previously mentioned findings from other studies that will repeatedly be referenced. First, Higgins et al. (2012) found that after a one-day workshop focused on interdisciplinary approaches to sexuality, healthcare professionals reported increased levels of comfort with sexuality. Additionally, Helland, Garratt, Kjeken, Kvien, and Dagfinrud (2013) reported that healthcare providers who had training and/or education with sexuality-specific instruction felt increased comfort discussing sexual-related topics with clientele. These researchers suggest that education and/or training in sex-related topics and sexuality can have positive impacts on healthcare professionals’ comfort and willingness levels when discussing associated topics with clients. Being that this study found comfort and willingness to be a leading variable for a clinician’s probability to take a sexual history, it would provide further evidence that there should be an increase in human sexuality education and training for mental health professionals.

When specifically focusing on mental healthcare, research has shown that mental health professionals who receive sexuality education and training report increased comfort and willingness to discuss sexual health-related topics with clients (Cupit, 2010; Flaget-Greener et al., 2015). Furthermore, this study found that both comfort and willingness showed there was a positive statistically significant relationship, but adding attitude as a predictor did not show any
positive statistically significant relationship. Finally, researchers over several decades have found a variety of evidence linking the lack of or hindered sex and human sexuality discussions to low and reduced comfort and willingness stemming from the overall lack of education and training of mental health clinicians regarding the topic of mental health’s connection to sex and human sexuality (Cupit, 2010; Flaget-Greener et al., 2015; Graham & Smith, 1984; Harris & Hays, 2008; Hartl et al., 2007; Hilton, 1997; Papaharitou et al., 2008; Reissing & Giulio, 2010; Weerakoon et al., 2008; Zeglin, Van Dam, & Hergenrather, 2018). The next find focuses on sexual history taking.

As stated in an earlier chapter, one of the most basic and introductory strategies to increase sexual communication between mental health professionals and clients would be clinicians taking a thorough sexual history from clients. As previously stated, one of the most important ways to identify, treat, and promote sexual health is a thorough sexual history taking by clinicians (Jones & Barton, 2004; Ribeiro et al., 2014). This study found that there was a positive, statistically significant relationship between human sexuality education and training the clinicians’ probability to complete a sexual history. Because of the aforementioned links to increased sexual history taking, this research study shows it to be advantageous for clinicians working in college counseling centers to receive human sexuality education and training. This can be done through workshops and/or professional development provided directly by university and college counseling centers. Also, if individual college mental health clinicians find this to be an area of interest or an area of which they would like to improve, they can seek out training and supervision on their own. Being that mental health professionals need continuing education hours in order to renew their credentials and licenses to practice, this gives both university counseling centers as well as the staff ample opportunities to receive human sexuality education
and training. Given that this study also found that most of the participants believed that additional training has prepared them the best to have therapeutic sex-based conversations with clients (i.e., 57.8% of the participants), it seems fitting that said training should be offered directly from university and college counseling centers. Another recommendation for university counseling centers is to utilize human sexuality education and training during supervision. LeViness, Bershad, Gorman, Braun, & Murray (2019) found that nearly 75% of university/college counseling centers provide clinical supervision to trainees, and almost 50% provide clinical supervision to unlicensed staff employees. These clinical supervision settings offer ample opportunities for human sexuality education and training after the supervision staff have themselves been trained.

Finally, I will address the recommendation for university and college counseling centers to incorporate sexual history taking into their intake procedures. From an anecdotal perspective, I have worked in a total of five different university counseling centers throughout my education, training, internships, and professional career. I can say quite honestly that not once, while being trained at any of these centers, have I been instructed to complete any kind of sexual history during the intake or throughout the counseling process. Additionally, outside of assessing for sexual/affection orientation and sexual assault, nowhere in the intake paperwork has a human sexuality-related question been found at any of the centers where I have worked. My study also found that only 37.3% of the participants assessed for sexual issues and concerns, and 45.7% would only initiate therapeutic sex-related questions when a client stated there is a concern. This further proves that university and college counseling centers are not training clinicians to complete a sexual history. This is concerning being that previously mentioned research has found that many patients and clients will not initiate communication regarding sexual matters with their
healthcare providers, believing that if sexual issues were important, then the clinician would initiate the communication; furthermore, clinicians believe if there were an issue or problem that patients or clients would initiate this topic (Abramsohn et al., 2013; Althof, Rosen, Perelman, & Rubio-Aurioles, 2013; Kingsberg, 2004; Lindau et al., 2012; Lindau et al., 2007; Marwick, 1999; Wimberly, Hogben, Moore-Ruffin, Moore, & Fry-Johnson, 2006). Given that recent research has shown that nearly half of all young women (48%) and nearly a fourth of the young men (23%) are living with a minimum of one sexual issue or concern (Moreau, Kagesten, & Blum, 2016), I recommend that the intake paperwork as well as the clinicians performing the intake at university and college counseling centers include in-depth human sexuality-related questions regarding sexual issues and concerns. In addition, I recommend that mental health professionals working in these centers be trained to complete a sexual history intake.

**Mental Health Education Programs**

The results of this study also have many implications for recommendations for mental health educational programs where future college and university mental health clinicians will receive their education and training. Except for college counseling and student affairs programs, most mental health education programs do not have specific college counseling tracks. Therefore, it is safe to say that many of the mental health professionals working in college counseling and university centers were trained within general mental health education programs. This is to say that these recommendations can be made for nearly all mental health education programs, not just those specific to college and university counseling. As a person who graduated from a college counseling master’s program is currently finishing a Ph.D. in counselor education and supervision, along with my study’s findings of a positive statistically significant relationship between human sexuality education and training and a clinician’s probability to
complete a sexual history, I recommend various interventions best suited for mental health educational programs. Interventions recommended based on my study include a) mental health educational programs to include human sexuality courses in their offered courses, b) mental health education professors and instructors to integrate human sexuality education and training into already offered courses, and c) for individuals working in mental health education programs to pressure accreditation associations to include human sexuality education in the required curriculum.

When addressing the recommendation that mental health education programs include human sexuality courses in their offered courses, my study found that only 38.6% of the participants had the opportunity to take a course directly related to human sexuality, and 61.4% never had the opportunity to take a course directly related to human sexuality. Furthermore, only 15.7% reported that a human sexuality course was required. This study also found that 100% of the participants reported that they had provided counseling to clients that related to human sexuality or sexual issues. Finally, when asked if the participants believed it was the responsibility of the counselor to provide counseling to clients regarding issues related to human sexuality and sexual issues, 0.0% reported no. In short, mental health professionals working in college and university counseling centers are not directly educated or trained during their programs on human sexuality, but all of these mental health professionals are providing care related to human sexuality, and they all agree to some level that providing human sexuality education and training to college student cliental is, in fact, their responsibility.

Again, one of the most basic and introductory strategies to increase sexual communication between mental health professionals and clients would be for clinicians to takes sexual history from clients. Also, one of the most essential ways to identify, treat, and promote
sexual health is a thorough sexual history taking by clinicians (Jones & Barton, 2004; Ribeiro et al., 2014). Given the findings of my study showing that human sexuality education and training increase the probability of college and university mental health professionals taking a sexual history from clients, it would be to the advantage of said professionals, as well as their clients, to take a human sexuality course during their graduate programs. As previously stated, research shows that human sexuality education and training positively correlate with clinicians’ comfort levels and willingness to have sex-specific conversations with their clients (Cupit, 2010; Flaget-Greener et al., 2015).

When addressing the recommendation that mental health education professors and instructors integrate human sexuality education and training into already-offered courses, my study found that only 33.7% of participants feel as though their graduate programs had best prepared them for counseling clients on issues related to human sexuality. Again, given the aforementioned importance, demand, and responsibility for university and college mental health professionals to provide human sexuality-related therapy, graduate programs need to provide some level of human sexuality education and training, even if it is not by the way of an entire graduate-level course. I would again like to point out that Higgins et al. (2012) found that after a one-day workshop focused on interdisciplinary approaches to sexuality healthcare, professionals reported increased levels of comfort with sexuality. This, also with my study’s findings that increased human sexuality education and training also make clinicians more likely to initiate sex-based conversations by the way of sexual history taking, provides a clear rationale for professors and instructors of mental health education courses to incorporate human sexuality education and training. This education and training could even be incorporated into some of the already-required coursework mandated by accrediting associations. Some of these include but are not
limited to human growth/development courses, lifespan courses, multicultural courses, social psychology, and behavioral psychology. Again, ongoing and repeated human sexuality and education will continue to build higher comfort levels and more willingness for clinicians to have sex-based conversations by the way of sexual history taking with clients, according to my research.

Finally, I will address the recommendation for individuals working in mental health education programs to pressure accreditation associations to include human sexuality education in the required curriculum. Accreditation programs play a vital role in the shaping of mental health education programs (Callahan, 2019; Grus, 2019). Said accreditation organizations often will revisit and revise their standards every several years. Usually these accreditation organizations will only accept suggestions, recommendations, and feedback during these given revision periods. Given all of the aforementioned information regarding the importance and need for increased human sexuality education and training, it could be advantageous for individuals involved with mental health education programs to provide feedback and put pressure on specific accreditation associations to require some level of human sexuality training to remain an accredited program.

**Recommendations for Future Research**

In addition to recommendations for mental health professionals working at college and university counseling centers and mental health education programs, recommendations for future research also emerged from this study. As previously stated, this study utilized qualitative data, which was unable to demonstrate a complete context of mental health clinicians' descriptions of their probability to take a sexual history. This survey design method is not designed to capture all the contexts or reasons regarding mental health college clinicians’ probability to take a sexual
history. The primary goal of this study was not to provide a comprehensive particularization but instead a broader generalization of macro-scale understanding. Now that the data has been analyzed and reported, it would be interesting to conduct a more in-depth qualitative study that would reveal a more complete context as to why mental health clinicians working at college and university counseling centers are or are not completing sexual history intakes with their clients.

Another interesting area for future research would be to focus similar studies in other specialty areas of mental health. This study demonstrated findings, particularly in university and college counseling settings, but there are many other areas of mental health that could show vastly different results. Community mental health settings see a much more diverse sector of the population, and one could suspect that the results of a similar study within a community mental health context may find different and interesting distinctions. Another specialty area that I suspect would find infinitely diverse results is relationship and sex therapy. Being that sex and human sexuality is a much more germane topic within these settings, there is a chance that one would find an increased probability to complete a sexual history with clientele. I would also suspect results would find perhaps more of an increase in comfort and willingness levels to provide sex-based therapeutic counseling to clients. The opposite also may be seen if a similar study were to be done in a school or high school setting. While sex-based therapeutic counseling may still be relevant in these settings, I would suspect a decrease in comfort, willingness, and probability to complete a sexual history. Really, another niche sector of mental health could produce different results.

Another interesting area of future research would be looking directly at some of the demographics. For instance, does the age of the mental health clinician make them more or less likely to complete a sexual history? Does the age of mental health clinicians change the levels of
comfort and willingness to have sex-based therapeutic conversations with clients? The age of the client may also be a contributing factor to the results. When studying college and university counseling centers, clinicians are likely to have a relatively younger population consisting of young adults. Researchers studying mental health clinicians who work with elderly populations may conclude vastly different results from this study. Again, really any of the demographic qualifiers, when utilized as a contributing variable, could produce interesting and useful information. Some of the most interesting that I may even try to analyze with the current data include years of service within the field, aforementioned age, gender and sex of both clinician and client, and minority status. Based on my sample size and collective distribution of my current data, some of these demographic results could be produced for further findings.

One interesting idea that came to me while looking at my results had to do with the fact that attitude did not produce a positive correlation to completing a sexual history in the way that comfort and willingness did. Upon going back and looking at Hendrick et al.’s (2006) Brief Sexual Attitudes Scale that was used to measure said variable, many of the questions in the survey registered as very vanilla by today’s standards. For example, in 2006, attitudes about casual sex, birth control, and multiple sexual partners may be very different from the attitudes of today’s mental health clinicians. Judging by what I know about peer-reviewed journal publication timelines, chances are that the data used to create this scale is most likely about 20 years old now. A lot has changed with today’s culture and within the collective minds of modern individuals. These particular topics may not be as controversial as they once were and, therefore, do not reflect the exact measurement of attitude and willingness that they once did. This, of course, can be said about any scale that measures public opinion surrounding sensitive topics.
This is why it is important for social science researchers to continue to replicate studies and why we do not continue to use and cite outdated data.

Finally, as previously mentioned, this study began before the global pandemic through which we are suffering. By the time it was proposed, the world had changed immensely in the way that we interacted with one another. College and university counseling centers around the country, if not the world, changed how they provide care. While telehealth had been around for a while before the COVID pandemic, the practice was not nearly as widely utilized as it was during the pandemic. Many mental health providers still continue to use telehealth. The data for this study was collected between April 28, 2021, and June 8, 2021. Most universities and colleges were still functioning remotely; this included university counseling centers. When this data was collected, the vast majority of the participants had been providing telehealth for over a year. Chances are that this was a new practice for many, if not most/all, of the participants of this study. All of that being said, the timing at which the data for this study was collected could have vastly altered the results. Recent research has found that many people find telehealth to be less connecting and impersonal (Connolly, Miller, Lindsay, & Bauer, 2020; Gajarawala & Pelkowski, 2021; Gordon, Solanki, Bokhour, & Gopal, 2020; Patel et al., 2021). Given that sex and human sexuality can be a more sensitive topic, it would be interesting to see if there is a difference between providing care face-to-face in the office versus virtually via telehealth.

**Conclusion**

A total of 83 mental health professionals working at university and college counseling centers participated in this study which explored the relationship between comfort, willingness, and attitudes about sex and human sexuality and their probability to complete a sexual history with clients. This study also explored the relationship between said populations’ human sexuality
education and training and their probability to complete a sexual history with clients. The results indicated that there was a positive, statistically significant relationship between comfort, willingness, and attitude levels when communicating with clients about sex and human sexuality and the clinicians’ probability to take a sexual history. When broken down individually, both comfort and willingness showed there was a positive statistically significant relationship, but adding attitude as a predictor did not show any positive statistically significant relationship. Furthermore, results also indicated that there was a positive, statistically significant relationship between human sexuality education and training the clinicians' probability to complete a sexual history.

This study contributes to the knowledge of mental health professionals working at university and college counseling centers and mental health education programs. This study presented a deeper understanding of the factors that may influence the willingness of mental health professionals working at university and college counseling centers to complete a sexual history with their clientele. As suggested from the recommendations sections in this chapter, it may be advantageous for mental health professionals working in this field to receive human sexuality education and training. Doing so may increase comfort and willingness to have therapeutic sex-based conversations with their clients. This could be done by the way of starting said conversations via sexual history taking in the early stages of therapy. By doing this, clients would be more likely to know that these topics are on the table for discussion, and they may feel less embarrassed and hesitant to bring up sexual issues and difficulties related to human sexuality. This study provides empirical evidence of some of the ways to increase the probability of mental health clinicians working in university and college counseling centers to complete a sexual history with clients. From this study, it is my hope that additional research will be
conducted to further understand, advocate for, and help individuals seeking mental health services who may be dealing with sexual issues and difficulties related to human sexuality.
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APPENDIX A

RECRUITMENT SCRIPT
Dear Mental Health Professionals,

My name is Adam Gregory, and I am a doctoral candidate at Northern Illinois University working toward completing the degree requirements for our Counselor Education and Supervision program. I, along with the co-investigator, Dr. Adam Carter, Assistant Professor of Counseling at Northern Illinois University, are seeking participants for a study that will explore the relationship between human sexuality education/training and the work of mental health professionals working in college counseling centers (IRB: HS21-0412). We are seeking your participation in this study. We are also asking that you to please forward this information and survey link to any colleagues and coworkers who also meet the below stated participation criteria. The online survey will take approximately 20 to 25 minutes to complete.

In order for you to participate, you:

1) Must be a licensed mental health professional (e.g. psychologist, licensed clinical social worker, counselor, marriage and family therapist, etc.)
2) Must work for an accredited university or college counseling center within the United States

Exclusionary criteria include current students completing practicum or internship at college counseling centers.

Participants can click the link to read more information about the study:

https://niu.az1.qualtrics.com/jfe/form/SV_b4uVMYc6TASTKgR

If you have concerns or questions about this study, please contact the primary researcher – Adam Gregory at Z1808534@students.niu.edu, his dissertation chair at Northern Illinois University at adamcarter@niu.edu, or the office of Research Compliance at Northern Illinois University at (815) 753-8588.

Thank you in advance for your time and consideration.

Adam Gregory
APPENDIX B

INFORMED CONSENT
Informed Consent

Purpose of Study: This study (IRB: HS21-0412) is being conducted by Adam Gregory, a Doctoral Candidate in the Counselor Education and Supervision program at Northern Illinois University. This proposed study will explore the relationship between human sexuality education and training of mental health professionals’ working in college counseling centers. Specific variables include the aforementioned human sexuality education and training, as well as comfort, willingness, and attitude levels of mental health professionals’ working in college counseling centers when communicating with clients about sex and human sexuality. Finally, this proposed study will also explore the relationship between all of the aforementioned variables and the probability of mental health professionals’ working in college counseling centers to take a sexual history from clients.

What will be done: You will complete a survey, which will take about 20-25 minutes to complete. The survey includes questions about mental health professionals’ education and the college counseling profession. Most questions will require a response on a Likert scale. The survey will collect non-identifying demographic information such as years in the counseling profession, education information, training program, type of license(s), as well as a number of questions pertaining to sex-based and human sexuality communication with clients.

Benefits of this study: You will be contributing to knowledge about mental health professionals’ education and training as well as mental health professionals working in college and university settings.

Risks or discomforts: No risks or discomforts are anticipated from taking part in this study. If you feel uncomfortable with a question, you can skip that question or withdraw from the study altogether. If you decide to quit at any time before you have finished the questionnaire, your answers will NOT be recorded.

Confidentiality: Your responses will be kept completely confidential. I will not know your IP address when you respond to the Internet survey. I will not ask for any specific identifying information in this survey. Your identity will remain completely confidential. The survey data will be encrypted and stored in Qualtrics and exported data will be stored electronically in a password protected file.

Decision to quit at any time: Your participation is voluntary; you are free to withdraw your participation from this study at any time. If you do not want to continue, you can simply
leave this website. If you do not finish the survey, your answers and participation will not be recorded. You also may choose to skip any questions that you do not wish to answer.

**How the findings will be used:** The results of the study will be used for scholarly purposes only, including the primary investigator’s doctoral dissertation. The results from the study will be presented in educational settings and possibly at professional conferences. Finally, the results may be published in professional journals in the field of counseling or other related fields.

**Contact information:** If you have concerns or questions about this study, please contact the primary researcher – Adam Gregory at Z1808534@students.niu.edu, his dissertation chair at Northern Illinois University at adamcarter@niu.edu, or the office of Research Compliance at Northern Illinois University at (815) 753-8588.

**By beginning the survey, you acknowledge that you have read this information and agree to participate in this research; with the knowledge that you are free to withdraw your participation at any time without penalty.**
APPENDIX C

DEMOGRAPHICS QUESTIONNAIRE
Are you currently employed as a licensed mental health clinician for a college, university, or educational equivalent counseling center? (If you have any tiered license, you should answer "Yes").

Yes
No

Is the university/college/education counseling center accredited by a recognized scientific and/or professional accreditation organization (e.g., American Psychological Association, American Counseling Association, International Association of Counseling Services, etc.)?

Yes
No

How do you identify your sex?
Male
Female
Not Listed ________________________________________________

How do identify your primary racial identification?
American Indian or Alaska Native
Asian or Indian
Black or African American
Hispanic or Latino
Native Hawaiian and Other Pacific Islander
Mixed Race
Unknown
White or Caucasian
Not Listed ________________________________________________

Q33 How do identify your religious affiliation?
Agnostic
Atheist
Buddhist
Christian
Hindu
Jewish
Muslim
Other (please specify) ________________________________________________

To what level of importance does religion play a role in your life?
Very Important
Important
Neutral
Unimportant
Very Unimportant
What is your age?

_______

How many completed years of experience do you have working as a licensed professional counselor in a college setting?

- 0-5 Years
- 6-10 Years
- 11-15 Years
- 16-20 Years
- 20+ Years

What characterizes your position status?

- Full-time
- Part-time
- Other (please specify) ____________________________________________________________

How would you best describe the setting within which you work?

- University/College Counseling Center
- Community/Junior College Counseling Center
- Vocational School Counseling Center
- Online Institution Counseling Center
- Other (please specify) ____________________________________________________________

How would you best describe the type of institution within which you work?

- Public
- Private-Religious
- Private-Non-Religious
- Other (please specify) ____________________________________________________________

What are your current credentials? Check all that apply.

- Counselor
- Family and Marriage Therapist
- Psychiatrist
- Psychologist
- Social Worker
- Other (please specify)

How would you best describe your highest educational degree?

- Bachelor's Degree
- Master's Degree
- Doctoral Candidate
- Doctorate Degree
- Other (please specify)
Did you complete a graduate level counseling course devoted primarily to aspects of human sexuality?
- YES, it was an ELECTIVE
- YES, it was REQUIRED
- Human sexuality was not a primary focus in any single course, BUT it was incorporated into other classes
- NO, there was no content related to human sexuality in my program

What education or training has best prepared you for counseling students regarding issues related to human sexuality?
- Graduate course in Human Sexuality
- Graduate course in Multicultural Counseling
- Graduate course in Marriage and Family Counseling
- Graduate course in Professional Ethics
- Graduate course in Human Growth and Development / Lifespan Counseling
- Other course not listed above
- Additional training (e.g., continuing education, workshops, in-services)
- None of the above

Do you believe it is a responsibility of the licensed professional counselor to provide counseling to clients regarding issues related to human sexuality?
- Yes
- No
- Unsure

Have you ever provided counseling to a client on an issue associated with human sexuality (e.g., vaginal sex, oral sex, anal sex, masturbation, sexually transmitted infections, pregnancy, contraceptive use, religious views, abortion, morals, homosexuality, bisexuality, homophobia, sexual harassment, sexual abuse, rape, etc.)?
- Yes
- No
APPENDIX D

THE PROFESSIONAL SCHOOL COUNSELORS’ PERCEPTIONS OF PREPAREDNESS TO COUNSEL STUDENTS ON HUMAN SEXUALITY SCALE
The Professional School Counselors' Perceptions of Preparedness to Counsel Students on Human Sexuality Scale (Behun, Cerrito, Delmonico, & Campenni, 2017)

Please rate how strongly you agree or disagree with each of the following statements by clicking on the appropriate bubble.

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Moderately agree</th>
<th>Neither agree nor disagree</th>
<th>Moderately disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
</table>

My professional mental healthcare education and training program prepared me with the knowledge to address questions, concerns, and issues related to clients' sexual behaviors (e.g., vaginal sex, oral sex, anal sex, masturbation).

My professional mental healthcare education and training program prepared me with the skills to address questions, concerns, and issues related to clients' sexual behaviors (e.g., vaginal sex, oral sex, anal sex, masturbation).

My professional mental healthcare education and training program helped to develop my self-awareness, which enhanced my ability to counsel clients about sexual behaviors (e.g., vaginal sex, oral sex, anal sex, masturbation).

My professional mental healthcare education and training program prepared me with the knowledge to address questions, concerns, and issues related to clients' sexual health (e.g., sexually transmitted infections, pregnancy, contraceptive use).

My professional mental healthcare education and training program prepared me with the skills to
address questions, concerns, and issues related to clients’ sexual health (e.g., sexually transmitted infections, pregnancy, contraceptive use).

My professional mental healthcare education and training program helped to develop my self-awareness, which enhanced my ability to counsel clients about sexual health (e.g., sexually transmitted infections, pregnancy, contraceptive use).

My professional mental healthcare education and training program prepared me with the knowledge to address questions, concerns, and issues related to clients’ sexuality and morality (e.g., religious views, abortion, morality).

My professional mental healthcare education and training program prepared me with the skills to address questions, concerns, and issues related to clients’ sexuality and morality (e.g., religious views, abortion, morality).

My professional mental healthcare education and training program helped to develop my self-awareness, which enhanced my ability to counsel clients about sexuality and morality (e.g., religious views, abortion, morality).

My professional mental healthcare education and training program prepared me with the knowledge to address questions, concerns, and issues related to clients’ sexual
identity (e.g., homosexuality, bisexuality, homophobia).

My professional mental healthcare education and training program prepared me with the skills to address questions, concerns, and issues related to clients' sexual identity (e.g., homosexuality, bisexuality, homophobia).

My professional mental healthcare education and training program helped to develop my self-awareness, which enhanced my ability to counsel clients about sexual identity (e.g., homosexuality, bisexuality, homophobia).

My professional mental healthcare education and training program prepared me with the knowledge to address questions, concerns, and issues related to clients' sexual violence (e.g., sexual harassment, sexual abuse, rape).

My professional mental healthcare education and training program prepared me with the skills to address questions, concerns, and issues related to clients' sexual violence (e.g., sexual harassment, sexual abuse, rape).

My professional mental healthcare education and training program helped to develop my self-awareness, which enhanced my ability to counsel clients about sexual violence (e.g., sexual harassment, sexual abuse, rape).
APPENDIX E

COMFORT AND WILLINGNESS SCALE
Comfort and Willingness Scale (Harris & Hays, 2008)

Every therapist has a system for assessing and initiating discussions about specific client problems. Please answer how much the following statements reflect your practice habits regarding the assessment and initiation of discussions on sexuality-related issues.

I assess for and initiate therapeutic conversations on:

<table>
<thead>
<tr>
<th>Topic</th>
<th>Always</th>
<th>Most of the time</th>
<th>About half the time</th>
<th>Sometimes</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexually transmitted diseases/infections</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual dysfunction</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client satisfaction with their sexual life</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client sexual interaction pattern</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reproduction</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contraception</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual orientation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual relationship enhancement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-consensual sex as victim</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-consensual sex as perpetrator</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The impact of drugs and alcohol on sexual health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The impact of mental illness on sexual health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The impact of medical problems on sexual health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How sexuality was expressed/discussed in family of origin</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STI/HIV protection</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client satisfaction with his/her body</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The impact of the presenting problem on client sexual health
Cultural sexual values
Religious sexual values

Please indicate how comfortable you are or would be discussing the following groups:

<table>
<thead>
<tr>
<th>Group</th>
<th>Extremely comfortable</th>
<th>Moderately comfortable</th>
<th>Neither comfortable nor uncomfortable</th>
<th>Moderately uncomfortable</th>
<th>Extremely uncomfortable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students/Trainees</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Supervisors</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Colleagues</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Male Clients</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Female Clients</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Sexual Minority Clients</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Client Ethnicity</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Difference from my own</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Elderly Clients</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Teenaged Clients</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pre-teenaged Clients</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Physically Disabled Clients</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mentally Disabled Clients</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Please indicate your reactions to the following statements using the following scale:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree</th>
<th>Moderately agree</th>
<th>Neither agree nor disagree</th>
<th>Moderately disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I respond openly and confidently when my sexual values are challenged.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I communicate effectively about human sexuality.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I use sexual vocabulary which is appropriate to the situation.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I am sensitive to and respectful of others’ feelings and anxieties towards sexual matters.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I encourage clients to explore their own sexual issues.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I encourage clients to explore their own sexual values.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I am not concerned about how I influence client human sexuality.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I am confident in my knowledge about human sexuality.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I appear poised in sessions when addressing sexual matters.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I find myself lacking respect for and feeling intolerant of others sexual values and practices.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>
APPENDIX F

BRIEF SEXUAL ATTITUDES SCALE
**Brief Sexual Attitudes Scale (Hendrick et al., 2006)**

Listed below are several statements that reflect different attitudes about sex. For each statement fill in the response on the answer sheet that indicates how much you agree or disagree with that statement. Some of the items refer to a specific sexual relationship, while others refer to general attitudes and beliefs about sex. Whenever possible, answer the questions with your current partner in mind. If you are not currently dating anyone, answer the questions with your most recent partner in mind. If you have never had a sexual relationship, answer in terms of what you think your responses would most likely be.

For each statement:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree with statement</th>
<th>Moderately agree with the statement</th>
<th>Neutral - neither agree nor disagree</th>
<th>Moderately disagree with the statement</th>
<th>Strongly disagree with the statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>I do not need to be committed to a person to have sex with him/her. Casual sex is acceptable.</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>I would like to have sex with many partners. One-night stands are sometimes very enjoyable.</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>It is okay to have ongoing sexual relationships with more than one person at a time. Sex as a simple exchange of favors is okay if both people agree to it. The best sex is with no strings attached. Life would have fewer problems if people could have sex more freely. It is possible to enjoy sex with a person and not like that person very much. It is okay for sex to be just good physical release. Birth control is part of responsible sexuality.</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
</tbody>
</table>
A woman should share responsibility for birth control.
A man should share responsibility for birth control.
Sex is the closest form of communication between two people.
A sexual encounter between two people deeply in love is the ultimate human interaction.
At its best, sex seems to be the merging of two souls.
Sex is a very important part of life.
Sex is usually an intensive, almost overwhelming experience.
Sex is best when you let yourself go and focus on your own pleasure.
Sex is primarily the taking of pleasure from another person.
The main purpose of sex is to enjoy oneself.
Sex is primarily physical.
Sex is primarily a bodily function, like eating.
APPENDIX G

SEXUAL HISTORY TAKING SCALE
**Sexual History Taking Scale (Ariffin et al., 2015)**

Frequency: Here are some issues that are presented to licensed mental healthcare professionals by their clients. Please answer as to how frequently these topics are discussed by clients with you.

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Frequent</th>
<th>Moderately frequent</th>
<th>Neither frequently nor non-frequently</th>
<th>Moderately non-frequently</th>
<th>Not frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual Behaviors (e.g., vaginal sex, oral sex, anal sex, masturbation)</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Sexual Health (e.g., sexually transmitted infections, pregnancy, contraceptive use)</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Sexuality and Morality (e.g., religious views, abortion, morality)</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Sexual Identity (e.g., homosexuality, bisexuality, homophobia)</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Sexual Violence (e.g., sexual harassment, sexual abuse, rape)</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

I only assess and initiate conversations on sexuality-related issues when the client states that it is a concern.

- Strongly agree
- Moderately agree
- Neither agree nor disagree
- Moderately disagree
- Strongly disagree
Please indicate how comfortable you are or would be discussing sexuality issues in the following modalities:

<table>
<thead>
<tr>
<th></th>
<th>Extremely comfortable</th>
<th>Moderately comfortable</th>
<th>Neither comfortable nor uncomfortable</th>
<th>Moderately uncomfortable</th>
<th>Extremely uncomfortable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Couple</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supervision</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
APPENDIX H

IRB APPROVAL
Exempt Determination

20-Apr-2021
Adam Gregory (01808534)
Counseling, Adult and Higher Education

RE: Protocol # HS21-0412 "The Examination of the Relationship Between Human Sexuality Education/Training and Mental Health Professionals Working in College Counseling Centers"

Dear Adam Gregory,

Your application for institutional review of research involving human subjects was reviewed by the Office of Research Compliance, Integrity, and Safety on 20-Apr-2021 and it was determined that it meets the criteria for exemption 2.

Although this research is exempt, you have responsibilities for the ethical conduct of the research and must comply with the following:

Amendments: You are responsible for reporting any amendments or changes to your research protocol that may affect the determination of exemption and/or the specific category. This may result in your research no longer being eligible for the exemption that has been granted.

Record Keeping: You are responsible for maintaining a copy of all research related records in a secure location, in the event future verification is necessary. At a minimum these documents include: the research protocol, all questionnaires, survey instruments, interview questions and/or data collection instruments associated with this research protocol, recruiting or advertising materials, any consent forms or information sheets given to participants, all correspondence to or from the IRB, and any other pertinent documents.

Please include the protocol number (HS21-0412) on any documents or correspondence sent to the IRB about this study.

If you have questions or need additional information, please contact the Office of Research Compliance, Integrity, and Safety at 815-753-8588.

Please see the RIPS website for guidance on the impact of COVID-19 on research(including face-to-face data collection) https://www.niu.edu/divresearch/covid