2021

Predicting Mental Health Counseling Professionals' Willingness to Discuss Sexuality Issues with Clients

Becca L. Thompson
Minnesota State University, Mankato

Predicting Mental Health Counseling Professionals' Willingness to Discuss Sexuality Issues with Clients

---

By

Becca L. Thompson

A Dissertation Submitted in Partial Fulfillment of

the Requirements for the Degree of

Doctor of Education

In

Counselor Education and Supervision

Minnesota State University, Mankato

Mankato, Minnesota

May 2021

May 5th, 2021

Predicting Mental Health Counseling Professionals' Willingness to Discuss Sexuality Issues with Clients

Becca L. Thompson

This dissertation has been examined and approved by the following members of the student's dissertation committee:

_____

Diane Coursol, PhD
Chair

_____

Jacqueline Lewis, PhD
Committee Member

_____

Richard Auger, PhD
Committee Member

_____

Ann Miller, PhD
Committee Member

ACKNOWLEDGEMENTS

There was and is such irony in this dissertation process, as I focused my research on the contributions of self-efficacy and anxiety in willingness to do something uncomfortable, I simultaneously felt challenged to develop my own self-efficacy in conducting research and writing academically. Despite my own growth and understanding, I have many individuals to thank for their support and assistance in this journey. First, and foremost, I am not sure that I would have gotten to this point or be writing this without the guidance and care of my advisor and mentor, Dr. Diane Coursol. I was so fortunate to have Dr. Coursol as my master's program advisor, where she provided me with such invaluable life lessons that have single-handedly shaped my professional and personal development. I am so grateful that she had taken me on as an advisee during the last leg of my doctorate program following a cycle of three previous advisors, during the most critical time of my academic career. She tirelessly dedicated many hours and efforts to encourage and direct me through this process. I cannot begin to thank her enough for her relentless support, and I am forever grateful. I would also like to express my deepest appreciation to the other members of my committee, Dr. Jacqueline Lewis, Dr. Richard Auger, and Dr. Ann Miller. They have all been so patient and flexible with my challenging timelines, have been active and involved, provided me important feedback and understanding in my research pursuits, and encouraging throughout this process. Also, I would like to extend a special thanks to my research and editorial consultant, Abbey. She worked diligently with me on learning and developing my research and writing mentality. She responded promptly during times of worry and was able to make room for me in her busy schedule to attentively answer all my questions and concerns.

And my sincere gratitude to my treasured family and friends. The unconditional love and support that you all have showed me has been humbling. Parents, your support never wavered, even though the many years it took me to get to this point. Mom, the compassion and nurturance you provided during all the trials and tribulations during this process has not been unnoticed. I am eternally grateful. Dad, thank you for all the assistance and last-minute labor you were tasked that undoubtedly helped me in my capacity to stay the course. My brother, Ben, and sister-in-law, Steph, have been so caring and encouraging of my focus and needs to finish this project. I am so grateful to have you in my life and support me in the ways that you have. To my fiancé, Brett, thank you. Your love and patience spoke volumes to your character and my future with you in this partnership. Your support means so much to me. To my future family, Kris, Jay, Mitch, and Ryanna. You have been an amazing cheer squad as I have taken quality time away from you to complete this project. Your positivity has been so heartening, and I am so thankful for you. Lastly, my friends, who have been hearing about “my dissertation” for far too long and yet, so attentive in every way to supporting and loving me throughout this process. I’m looking forward to returning my focus and energy back to our friendships.

TABLE OF CONTENTS

CHAPTER 1 1

Statement of the Problem 8

Purpose of the Study 12

Research Questions and Hypotheses 13

Definitions of Terms 14

Summary 17

CHAPTER 2: LITERATURE REVIEW 19

Sexual Intervention Self-Efficacy 20

Anxiety 28

Willingness to Initiate Sexual-Based Health Discussions with Clients 39

Conclusion 67

CHAPTER 3: METHODOLOGY 69

Purpose of the Study 69

Research Methodology and Rationale 70

Instruments 74

Data Screening and Descriptive Statistics 80

Conclusion 84

CHAPTER 4: RESULTS 85

Data Collection 85

Description of the Sample 86

Data Analysis and Results 93

Conclusion 98

CHAPTER 5: DISCUSSION 99

Summary of Results 100

Discussion of Results 102

Implications of the Findings 107

Limitations 111

Recommendations for Future Research 114

Conclusion 116

References 118

Tables 131

Appendices 136

Predicting Mental Health Counseling Professionals' Willingness to Discuss Sexuality with Clients

Becca L. Thompson

A Dissertation Submitted in Partial Fulfillment of
the Requirements for the Degree of
Doctor of Education in
Counselor Education and Supervision

Minnesota State University, Mankato
Mankato, Minnesota

2021

ABSTRACT

Sexuality is fundamental to the human experience and sexuality issues will affect every individual across the lifespan. Mental health counseling professionals (MHCPs) will likely encounter a client in their practice that presents with some facet of sexuality concern. MHCPs may be challenged by these disclosures or neglect to inquire about these needs due to underlying factors that contribute to decreased willingness to discuss sexuality with clients. This study explored the relationships of some of these factors, including sexual intervention self-efficacy, state anxiety, and trait anxiety, and further examined the extent to which these factors predict willingness to discuss sexuality with clients among licensed professional clinical counselors and licensed marriage and family therapists in the state of Minnesota. Participants completed an online survey that measured their sexual intervention self-efficacy, state anxiety, trait anxiety, and willingness to discuss sexuality with clients. Significant relationships were found between sexual intervention self-efficacy and state anxiety, sexual intervention self-efficacy and trait anxiety, and state anxiety and trait anxiety. Additionally, sexual intervention self-efficacy was found to statistically significantly predict willingness to discuss sexuality with clients. In accordance with the findings of this study, limitations, recommendations for future research, and implications for future practice are discussed.

CHAPTER 1

INTRODUCTION

"One might think we could take for granted what we are to understand by the word "sexual." Of course, the sexual is the indecent, which we must not talk about" (Freud, 1920, p. 262).

The field of mental health counseling is becoming increasingly more demanding, with environmental and social problems in the world evolving and becoming more complex (Mallicoat, 2014). More prevalent of these complexities is sexuality. Sexuality is a universal human experience and constitutes a significant factor of the human condition as well as determinant of overall sexual health (Diambre et al., 2016; Mallicoat, 2014). Sexuality underlines important behaviors and outcomes that are related to an individual's sexual health. This includes, but not exclusive to sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction (WHO, 2006). Sexuality encompasses many dimensions of the human experience and expression such as thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles and relationships (WHO, 2006). There is an impetus for Mental Health Counseling Professionals (MHCPs) to integrate multiple theories and perspectives, as sexuality is multidimensional and a central aspect to being human through life (Dupkoski, 2012; WHO, 2006).

Impact of Sexuality Issues

It is estimated that 10 to 52% of men, and 25 to 63% of women will develop and experience sexual problems in their lifetime (Heiman, 2002; Laumann et al., 1999). Interpersonally, 45% of couples experience a female, male, or couple sexual problem (Laumann et al., 1999). Further, it is estimated that 4.3% of adults aged 18 and older indicated that they are

of sexual minority, with 1.8% identifying as lesbian or gay, and 2.5% identifying as bisexual (Center for Behavioral Health Statistics and Quality [CBHSQ], 2016). The rates for substance use and mental health issues among sexual minority groups is higher than those who identify in the sexual majority (CBHSQ, 2016). Prevalence of pathological sexual difficulties is high, yet there are many other problems of sexuality that are not pathological in nature, which may contribute to an overwhelming emotional and psychological toll on individuals, such as sexual abuse and assault (Dupkoski, 2012).

Difficulties related to sexuality are extensive and can cause significant distress for clients. The spectrum of sexuality concerns that may pose difficulties for clients includes but is not limited to the way in which an individual experiences their sexual identities, sexual expressions, sexual relationships, pleasure, sexual dysfunction, reproduction, sexual violence, sexual practices, and sexually transmitted infection (STIs; Dupkoski, 2012; WHO, 2020). The etiology of sexuality difficulties can include both physiological factors, such as birth of a baby and disease, and psychosocial stressors, such as childhood sexual abuse (CSA) and religious beliefs (Dupkoski, 2012). The context in which sexual health related issues occur socially, culturally, and in the lifespan, can determine the impact and significance to the individual, and contribute to mental illness and health conditions, making human sexuality an integral psychosocial factor in an individual's life (Kalra et al., 2015). Likewise, those that experience mental health conditions have a higher likelihood to suffer more difficulties related to their sexual health, especially women living with mental illness (Blalock & Wood, 2015; Southern & Cade, 2011). An individual's sexual behavior and functioning is impacted by their mental illness, including intrapersonal and interpersonal ramifications (Dupkoski, 2012). Even more difficult are the adverse effects that the treatment of mental illness can have on sexuality issues, such as the

impact of prescription medications. Due to the intersectionality of mental illness and sexuality concerns there is a high probability that clients seeking counseling will have experienced or currently be experiencing sexuality difficulties. It is, therefore, very likely that MHCPs who work specifically with couples will encounter clients facing problems with sexual functioning in their relationships (Fisher, 2019).

Barriers to Sexuality Discussions with Clients

Given the abundance of client needs that are related to their sexuality, it could be posited that MHCPs should be adept in working with clients regarding their sexuality (Wilson, 2019). However, this does not appear to be the case, as the field continues to uncover barriers that prevent MHCPs from having the knowledge, skill, attitude, or composure needed to initiate conversations about client sexuality or sexual concerns (Cupit, 2010; Dermer & Bachenber, 2015; Harris & Hays, 2008; Reissing & Di Giulio, 2010). Due to the influence of American culture that tends to regard sex as taboo, client disclosure or needs relating to sexuality may challenge a MHCP's values, competence, and comfort (Houghton, 2018). The physiological, psychological, or emotional arousal experienced in this interaction may influence an MHCP to respond negatively and inappropriately, or to avoid the client's sexuality related concerns all together (Anderson, 1986; Harris & Hays, 2008; Miller & Byers, 2008). For nearly 40 years, research has investigated the experience of MHCPs, including the factors contributing to these responses and the variables that predict more effective clinical behaviors to inform and optimize counselor education and training (Arnold, 1980; Houghton, 2018). Of the many variables investigated, several barriers have been identified including sexual discomfort, lack of sex education and training, insufficient sexual knowledge, and negative sexual attitudes.

Sexual comfort and anxiety. There is extensive research that has explored the construct of sexual comfort, the arousal that perpetuates anxiety and avoidance, as well as the role that counselor education programs have in circumventing this dilemma among Counselors-in-Training (CITs) (Anderson, 1986; Arnold, 1980; Cupit, 2010). Sexual comfort has been defined as a psychological complexity of sexual feelings, attitudes, and behaviors (Graham & Smith, 1984). Beyond the literature demonstrating a strong positive relationship between sexual comfort and sexuality discussions (Berman, 1996; Hays, 2002; Juergens et al., 2009; LoFrisco, 2013), research has also examined the effect and predictive abilities of sexual comfort, demonstrating that MHCPs who are not comfortable with sexuality tend to not initiate or engage in discussions about sexuality-based problems (Anderson, 2002; Hanzlik & Gaubatz, 2012; Harris & Hays, 2008; Hipp & Carlson, 2019; LoFrisco, 2013). Sexual comfort has been shown to be a mediating factor between other independent variables and MHCP's willingness to discuss sexual issues with clients, such as sexuality education and training and supervision of sexuality counseling (Flaget-Greener et al., 2015; Harris & Hays, 2008; Houghton, 2018).

The presence of anxiety, or general discomfort, can confound an MHCP's ability to address sexuality with clients (Harris & Hays, 2008). Despite the fact that researchers have reported that anxiety likely impacts the engagement of sexuality discussions, this construct has not been well studied, or investigations have used the construct of sexual comfort to explain general anxiety (Arnold, 1980). For example, Miller and Byers (2008) specifically examined sexual anxiety and its relationship to confidence of psychologists to initiate sexuality discussions with clients. Their findings indicated that there was no significant relationship, which was a surprising finding, given the evidence that physiological arousal (Bandura, 1997) has on MHCP's confidence (Miller & Byers, 2008; 2012). It was suspected that the measure used in this

study assessed the anxiety experienced relative to the participant's own sexuality instead of assessing the experience of anxiety in the presence of client sexual problems and concerns (Miller & Byers, 2008). Anxiety is an important variable, as the repercussions of an MHCP's anxiety coping mechanisms in response to fear, can have damaging effects on the client-counselor relationship (Arnold, 1980; Bandura et al., 1960). MHCPs could avoid, minimize, dismiss, exploit, or react negatively to client disclosures leading to ethical violations and/or client harm (Reissing & Di Giulio, 2010; Walenz, 2011).

Sex education and training. One of the most significant predictors confirming that sexuality discussions will take place among MHCPs has been that of sex education and training in counselor education programs (Flaget-Greener et al., 2015; Harris & Hays, 2008; Hays, 2002; Miller & Byers, 2009). Several studies focused on the indirect effect that sexuality education and training may have on the MHCP's willingness to initiate sexuality discussions with clients (Flaget-Greener et al., 2015; Harris & Hays, 2008). These researchers have hypothesized that if MHCPs can reflect upon and desensitize their arousal and biases to sexual material in their training programs, they could develop healthy attitudes, knowledge, and comfort in addressing sexual issues with clients (Houghton, 2018; Jaramillo, 2017).

Mallicoat (2014) identified four major themes in their exploration of counselors' perceptions of sexuality in counseling, identifying one of the themes to be the MHCPs' feelings of insufficient sexuality training in their respective counselor education programs. MHCPs typically receive generalized training in their counselor education programs that can be translated to a myriad of mental health concerns encountered in the field (Wilson, 2019). CITs are taught about evidence-based approaches and are encouraged to adopt a holistic approach to wellbeing, conceptualizing mental health conditions through the lens of biological, psychological, social,

and cultural factors rather than a narrow theoretical orientation (Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2016). Thus, CITs will likely enter the field with a basic foundation for providing mental health counseling following their coursework, practicum, and internship experiences, ill-equipped to address specialized needs, such as sexuality concerns with clients (Dupkoski, 2012; Haboubi & Lincoln, 2003; Wilson, 2019). Counselor education programs do not typically require human sexuality courses in their curriculum, particularly in those accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2016) in the entry level specialization areas of rehabilitation or marriage, couples, and family counseling. One additional professional organization that sets accreditation standards for counselor education programs, the Council on Accreditation for Marriage and Family Therapy Education (Commission on Accreditation for Marriage and Family Therapy Education [COAMFTE], 2017), does mention knowledge of sexuality in accrediting standards. However, both organizations focus on affirmative action and advocacy for sexual minorities rather than the multitude of sexuality issues facing individuals (CACREP, 2016; COAMFTE, 2017). The lack of training requirements in human sexuality among counselor education programs was reviewed by Gray and colleagues (1996) and reported that most of the human sexuality training being taught was integrated into other courses, and not a stand-alone course. More recent studies corroborate that human sexuality continues to be minimal significance in counselor education programs and is most typically integrated into other required courses (Mallicoat, 2014; Zamboni & Zaid, 2017). The lack of sexuality education in counselor training is concerning as research has demonstrated the positive relationship that it has on MHCP confidence, knowledge, and comfort in addressing sexual concerns with clients (Dupkoski, 2012; Harris & Hays, 2008; Miller & Byers, 2008).

Sexual intervention self-efficacy. Self-efficacy is defined as the belief that an individual has about their ability to perform tasks and is a construct that leads to more achievement than an individual who has low self-efficacy beliefs (Daniels & Larson, 2001). The theory of self-efficacy holds significant influence among educational programs, as it is the core of social cognitive learning theory (Bandura, 1977). The literature has focused on the role of self-efficacy in the development and training of MHCPs, particularly with regard to how to increase CITs' self-efficacy in order to be more effective in their counseling. Miller and Byers (2008) posited that an individual's beliefs about their ability to address and treat sexual concerns can be constructed around sexual intervention self-efficacy and hypothesized that self-efficacy would have a significance influence on whether an MHCP would engage in sexuality discussions. Several studies have examined sexual intervention self-efficacy and whether it would predict a MHCP's willingness to treat sexual concerns, and, have reported significant findings (Miller & Byers, 2008, 2012). The research has indicated that higher levels of sexual intervention self-efficacy has been related to an increased willingness of CITs and MHCPs to discuss sexuality issues with a client. Previous research has consistently reported self-efficacy to be a predictor of performance and willingness of CITs and MHCPs to address sexuality concerns of clients (Alvarez, 1995; Barbee et al, 2003; Barnes, 2004; Haag, 2008).

Other variables including sexual attitudes and sexual knowledge have also been investigated, yielding mixed findings (Bloom et al., 2016; Fisher et al., 1988; Flaget-Greener et al., 2015; Harris & Hays, 2008; Hays, 2002). Specifically, a MHCP's attitude towards sexuality has been found to have a strong relationship with initiation of sexuality discussions. Measures that were used to assess willingness to discuss sexual issues with clients has varied, and studies have reported a range of variables such as gender, age, theoretical orientation, and cultural

affiliations, have significantly predicted attitude, suggesting the findings are not conclusive (Hanzlik & Gaubatz, 2012). While sexual knowledge has also been reported to have a strong relationship with MHCPs' willingness to initiate sexuality discussions, there has also been consideration for the mediating effect it has (Fluharty, 1995; Harris & Hays, 2008). Additionally, type of professional licensure, accreditation affiliation, gender, and theoretical orientation have also been evaluated as potential contributing variables (Hayes, 2019; Hays, 2002).

Despite the extensive literature suggesting the significance of various factors either contributing to or impeding MHCPs engagement in discussions of sexuality issues with clients in counseling, research is needed to uncover what variables may serve as predictive of engagement in sexuality discussions and will ultimately inform counselor education programs.

Statement of the Problem

Sexuality is a fundamental core to the human condition and will affect every individual along the lifespan in some way (Southern & Cade, 2011). Every MHCP will encounter a client who presents with a sexuality concern, or at least a secondary problem related to sexuality (Bogey, 2008). Clients may not always present these concerns directly, but through exploration in the counseling process, the MHCP may identify that sexuality issues are at the core or the consequence of other mental health problems. However, the conversations to assess, explore, and elicit topics are not happening (Buehler, 2014; Wilson, 2019). It is suggested that there may be varying degrees of personal, as well as professional, factors contributing to a MHCP's lack of therapeutic response.

Sex has always been considered taboo in American society (Wilson, 2017). American culture collectively has had modest values regarding sexuality, which has in part been due to historical Puritan influence in the United States. Messages surrounding what is appropriate or not

appropriate to talk about have been passed down through history, creating schemas of embarrassment and shame (Hipp & Carlson, 2019). The age of the sexual revolution, in the 1960s, counselor educators were growing concerned that the helping professions were somewhat unwilling or unable to provide treatment to clients dealing with issues of sexuality (Arnold, 1980). During that time, Western countries were evolving more liberal attitudes towards sex, especially as Masters and Johnson (1966) were pioneering research into the human sexual response cycle. This led to an openness of discussions relating to human sexuality, and better examination of how professionals in the field were dealing with issues of human sexuality. Masters and Johnson (1970) pointed to the importance of a counselors' comfort with their own sexuality as being a determinate of their comfort with the sexuality of others. This large body of research has provided a wealth of insight to the mental health profession. However, the literature dramatically declined two decades later due to a societal change in perspectives about sexuality, leaving a gap in the literature on human sexuality in the counseling field. Despite the necessity of sexuality discussions in therapy, researchers have reported reluctance among both MHCPs and clients to address the issues (Buehler, 2014; Southern & Cade, 2011). In one investigation, Reissing and Di Giulio (2010) asked psychologists how often they were finding that clients asked about topics related to sexual health over the past year. These authors concluded that the majority of clients had indicated that they were only asked about their sexual health "a few times" in the past year and as few as one fourth of the clients indicated "not at all."

Despite the abundance of MHCP encounters with sexuality-based issues in counseling, it has been consistently demonstrated in the literature that MHCPs may be ill-equipped to address and intervene (Bloom et al., 2016; Harris & Hays, 2008; Hays, 2002; Miller & Byers, 2008). Training programs have engaged in some efforts to provide human sexuality education and

opportunities for CITs to develop the self-efficacy that is often sought after among MHCPs in the field (Bogey, 2008; Humphrey, 2000).

Dupkosko (2012) reported that counselor training programs were not addressing human sexuality instruction that many scholars felt were necessary to equip professionals with understanding and compassion for clients and their encompassing sexual problems. Berman (1997) questioned whether programs training mental health professionals were accessing sexual education opportunities with the same frequency and focus as other health professionals. The literature has previously focused on uncovering the factors that would equip MHCPs to address sexuality issues with clients. The problem is that there are not enough conclusive findings to be associated with what qualities clients expect MHCPs to possess in order to meet their sexuality needs when seeking treatment for their mental health concerns.

With the prevalence of client issues having some, if not all, relevance to sexuality, therapists should be competent and willing to address these issues. The literature points to a disparity between the necessity for MHCPs to inquire about, assess, and discuss client sexuality concerns and a lack of engagement in initiating these discussions within counseling sessions. Historically, many of the variables investigated in the literature have focused on external factors, despite the potential value of examining anxiety, an internal factor, that may offer greater understanding of the influence of personality characteristics on the apparent reluctance of MHCPs to engage in client concerns related to sexuality. While the literature has confirmed a relationship between external variables and an MHCP's willingness to address sexuality issues with clients, more recently research has focused on the identification of more internalized predictor variables in combination with external factors to understand the variables impacting willingness to address sexuality on the part of MHCPs. Some of these consistently reported

predictors have included attitudes about sex and sexuality (Cupit, 2010; Russell, 2012), human sexuality education and training, (Cupit, 2010; Harris & Hays, 2008), self-efficacy (Hipp & Carlson, 2019; Miller & Byers, 2008, 2012), supervision experiences (Cupit 2010; Harris & Hays, 2008; Moore, 2018); clinical experience (Moore, 2018), and age (Cupit, 2010; Miller & Byers, 2012; Traeen & Schaller, 2013). Thus, most of the literature has been committed to exploring these variables to better inform counselor education curricula in order to reduce the barriers in providing human sexuality education and training and enhancing the professional identity development among CITs.

Related, self-efficacy has consistently been found to be a strong correlate and predictor of MHCP performance (Alvarez, 1995; Bandura, 1997). Research has demonstrated a consistent relationship between anxiety and self-efficacy, indicating that lower levels of anxiety correlate with higher levels of self-efficacy. These findings suggest that there may be a connection between fear arousal and an individual's confidence, thus indicating the extent to which individuals are likely to perform a task (Alvarez, 1995; Bandura, 1956; 1977; 1983). Self-efficacy can be challenging to develop as it relates to specific tasks, producing great anxiety and fear, including sexual interventions in mental health counseling (Bandura, 1997; Miller & Byers, 2008). Therapists need to have self-efficacy in treating sexuality-based issues the same as they would with general counseling problems due to the significant impact that these sexuality concerns can have on a client's wellbeing.

The role of self-efficacy in therapist intervention effectiveness could be an integral contribution to the mental field and development of effective therapists. When MHCPs have not been adequately prepared in their counselor education programs to address sexuality concerns with clients through knowledge and skill acquisition, increased sexual awareness, and practical

experiences, then sexuality issues that clients present with may cause anxious distress and discomfort (Anderson, 1986; Arnold, 1980; Harris & Hays, 2008). It is important to better understand the role that anxiety plays in mediating a MHCP's ability to address or initiate sexual-based conversations with clients as well as identifying factors that can inform counselor education programs to prepare effective MHCPs for sexuality counseling.

The literature has supported the importance of focusing on the emotional responses and personality characteristics of MHCPs by examining state anxiety and trait anxiety, measured by the empirically developed State-Trait Anxiety Inventory (Spielberger, 1983). State anxiety refers to the "…subjective feelings of tension, apprehension, nervousness, and worry, and by activation or arousal of the autonomic nervous system" (Spielberger, 1983-2020, p. 6). Trait anxiety refers to the "relatively stable individual differences in anxiety- proneness, that is, to differences between people in the tendency to perceive stressful situation as dangerous or threatening and to respond to such situations with elevations in the intensity of their state anxiety" (Spielberger, 1983-2020, p. 7). This study explored state and trait anxiety as it had not previously been investigated in relation to a MHCP's willingness to initiate sexuality discussions with clients. In addition, sexuality intervention self-efficacy was also examined to explore its potential role in a MHCP's willingness to initiate sexuality discussion with clients.

Purpose of the Study

The purpose of this study was to contribute to the limited literature associated with MHCP's effectiveness in addressing sexuality with clients by exploring the relationships between sexual intervention self-efficacy, state anxiety, trait anxiety, and counselor willingness to discuss sexuality concerns with clients. Research has previously focused primarily on the implications of the disparity of sexuality in mental health counseling practice and has largely

been descriptive. Specifically, the focus had been on describing and identifying variables that may lead to an understanding of the challenges faced by counselor education programs in providing information and skill to CITs that has contributed to the discrepancy between client stated needs and a MHCP's inability to deliver services related to client sexual concerns. There have been only a few studies that have investigated the relationships of sexual intervention self-efficacy and a MHCP's willingness to discuss sexuality concerns and no investigation to date has investigated the potential influence of state and trait anxiety on MHCPs' willingness to engage in sexuality discussions with clients. Through examination of the possible relationships between sexual intervention self-efficacy, state anxiety, trait anxiety and willingness to discuss sexual issues with clients, this study provides counselor educators with descriptive and empirical evidence informing curricula for professional identity development of MHCPs.

Research Questions and Hypotheses

This exploratory study investigated the relationship between variables: sexual intervention self-efficacy, state anxiety, trait anxiety, and willingness to discuss sexuality issues with clients. Further, this study examined the contribution of each of the independent variables: sexual intervention self-efficacy, state anxiety, and trait anxiety in predicting the dependent variable: a MHCP's willingness to initiate sexuality discussions with clients. The following two research questions were used in this study:

Research Question 1. Is there a relationship between sexual intervention self-efficacy (as measured by SISEQ), state anxiety (as measured by STAI), and trait anxiety (as measured by STAI) among mental health counseling professionals (MHCPs)?

$H1_0$: There are no significant relationships between sexual intervention self-efficacy (SISEQ total score), state anxiety (STAI-S total score), and trait anxiety (STAI-T total score) among mental health counseling professionals (MHCPs).

$H1_a$: There are significant relationships between sexual intervention self-efficacy (SISEQ total score), state anxiety (STAI-S total score), and trait anxiety (STAI-T total score) among mental health counseling professionals (MHCPs).

Research Question 2. To what extent do sexual intervention self-efficacy (as measured by SISEQ), state anxiety (as measured by STAI-S), and trait anxiety (as measured by STAI-T) predict willingness to discuss sexual issues with clients (as measured by SDCS) among mental health counseling professionals (MHCPs)?

$H2_0$: Sexual intervention self-efficacy (SISEQ total score), state anxiety (STAI-S total score), and trait anxiety (STAI-T total score) will not significantly predict willingness to discuss sexual issues with clients (SDCS total score) for mental health counseling professionals (MHCPs).

$H2_a$: Sexual intervention self-efficacy (SISEQ total score), state anxiety (STAI-S total score), and trait anxiety (STAI-T total score) will significantly predict willingness to discuss sexual issues with clients (SDCS total score) for mental health counseling professionals (MHCPs).

Definitions of Terms

The following terms are used in this study:

Sexuality. An interplay of biological, psychological, socio-economic, cultural, ethical and religious/spiritual factors. A core dimension of being human that is experienced or expressed in thoughts, fantasies, desires, beliefs, attitudes, values,

activities, practices, roles, and relationships, essentially in all the individuals are, feel, do, and think (PAHO/WHO, 2001).

Sexual health. Includes and integrates somatic, emotional, intellectual, and social aspects of a sexual being. Experienced as the ongoing process of aspects of wellbeing related to sexuality. Sexual health is considered the free and responsible expressions of sexual capabilities, fostering and enriching wellness and quality of life (PAHO/WHO, 2001).

Counseling. The term "counseling" will be used and is shortened from "professional counseling," which is defined as "The application of mental health, psychological, or human development principles, through cognitive, affective, behavioral or systematic intervention strategies, that address wellness, personal growth, or career development, as well as pathology" (ACA, 2014).

Mental Health Counseling Professional (MHCP). The term "Mental Health Counseling Professional" refers to providers of professional counseling, encompassing couple and marriage counselors, clinical social workers, licensed psychologists, and clinical counselors.

Licensed Marriage and Family Therapist (LMFT). Licensed marriage and family therapists are "mental health counseling professionals trained in psychotherapy and family systems, and licensed to diagnose and treat mental and emotional disorders within the context of marriage, couples and family systems" (AAMFT, 2015)

Licensed Professional Clinical Counselor (LPCC): According to the American Counseling Association (2014) licensed professional clinical counselors ". . . are master's-degreed mental health service providers, trained to work with individuals,

families, and groups in treating mental, behavioral, and emotional problems and disorders".

Counselor in Training (CIT). Counselors in training are graduate-level students enrolled in a master's or doctorate counselor education program, working towards licensure or practice in professional counseling.

Client. The term "client" refers to an individual seeking or referred to the professional services of a counselor (ACA, 2014).

Sexual issues/concerns/problems/difficulties. The terms of "sexual issues," "sexual concerns," "sexual problems," and "sexual difficulties," will be used interchangeably in this document and refer to broad sexuality subject matter that a client may have as well as the psychological issues that accompany them (e.g., past sexual abuse experiences, sexual identity, loss of sexual desire, or excessive masturbation) that may surface during the course of professional counseling (Anderson, 1986; LoFrisco, 2013).

Sexuality discussions. The term "sexuality discussions" refers to the exploration, processing, conversing, inquiring, and disclosing of subject matter or material having to do with sex or sexuality in the client-counselor relationship.

Willingness (to initiate sexuality discussions with clients). The likelihood that the therapist will proactively broach, discuss, or address sexual issues with the client (Harris & Hays, 2008).

Sexual intervention self-efficacy. Sexual intervention self-efficacy consists of three components, (a) clinicians must feel that they can appear comfortable discussing sexual issues and prevent personal bias from interfering with treatment, (b) clinicians

must feel that they have the ability to relay accurate information about sexual issues, and (c) clinicians must be confident in their knowledge of and ability to utilize sex therapy techniques (Miller & Byers, 2012)

State anxiety. State anxiety can be defined as a transitory emotional state consisting of feelings of apprehension, nervousness, and physiological sequelae such as an increased heart rate or respiration (Spielberger, 1983-2020).

Trait anxiety. Trait anxiety can be defined as anxiety-proneness, which is described as a reflection of individual differences for which the frequency and intensity that anxiety states have manifested in the past, as well as the extent that anxiety states will be experienced in the future (Spielberger, 1983-2020).

Summary

This chapter provided an overview of the nature and purpose of this study. The purpose of this study was to investigate the relationship between sexual intervention self-efficacy, state anxiety, trait anxiety, and willingness to discuss sexuality issues with a client. MHCPs are confronted with unique challenges that will impact their clinical behaviors and treatment outcomes. As the prevalence of client dilemmas surrounding human sexuality increases, it is imperative to examine influences of MHCP's effectiveness in managing these difficulties. Research has demonstrated that sexual intervention self-efficacy has been shown to predict a MHCP's willingness to address and intervene with clients who present with sexual concerns. Previous research has not, however, examined the influences or relationships between personality characteristics (i.e., state and trait anxiety), sexual intervention self-efficacy, and MHCP's willingness to engage in sexuality discussions. This study examined these relationships

in order to evaluate the extent to which state anxiety, trait anxiety, and sexual intervention self-efficacy may influence a MHCPs willingness to initiate sexuality discussions with clients.

CHAPTER 2

LITERATURE REVIEW

Sexuality is integral to human functioning and overall wellbeing (WHO, 2020). Sexuality plays a significant role in both the development and consequence of mental illness (Kalra et al., 2015). Sexual issues are prevalent around the world, especially among clients seeking counseling (Laumann et al., 1999). And, MHCPs will be confronted with complex client needs, including mental health problems related to sexuality. Thus, it is imperative that MHCPs are equipped to address any and all concerns that challenge clients (Reissing & Di Guillio, 2010). However, sexuality has historically been considered taboo and holds a stigma that may prevent clients from disclosing concerns or even prevent MHCPs from initiating conversations with clients about the clients' sexuality due to fear, bias, or limited competence (Harris & Hays, 2008; Wilson, 2019). MHCPs may not have the competence to treat every concern a client presents, but it is fundamental that they have the willingness to initiate conversations that lead to an exploration of needs, referrals, and interventions (Reissing & Di Giullio, 2020). While the literature frequently posits that it is necessary for MHCPs to engage in discussions about sexual-based health concerns, the research remains exploratory in attempting to identify the variables that contribute to or interfere with a MHCP's ability to engage in these conversations (Miller & Byers, 2008; Russell, 2012). It, therefore, seems an important objective would be to conduct research that will inform counselor education programs about how to best prepare CITs in the skills necessary to engage clients in conversations about sexual concerns. (Dermer & Bachenberg, 2015; Harris & Hays, 2008; Juergens, et al., 2009).

Research has identified several predictors of a MHCP's willingness to initiate sexual-based health conversations with clients. The literature reports some predictive variables to be

stronger than others. Those investigated have included the role of sexual comfort, sexual attitude and bias, and sexual knowledge (Anderson, 2002; Arnold, 1980; Cupit, 2010; Hayes 2019; Hipp & Carlson, 2019; Russell, 2012). Nevertheless, there remain other variables that have not been well examined, including the role of sexual intervention self-efficacy and anxiety tendencies as predictors of MHCPs demonstrating the capacity to engage in sexually-based health conversations (Miller & Byers, 2008, 2012). The purpose of this study is to examine these predictor variables by investigating the relationships between sexual intervention self-efficacy, state anxiety, trait anxiety, and willingness to initiate sexuality discussions with clients (Harris & Hays, 2008).

This chapter will introduce the concepts of sexual intervention self-efficacy, state anxiety, trait anxiety, and willingness to initiate sexuality discussions with clients among MHCPs. The review of the literature pertaining to these areas of research will demonstrate the significance of this study and its potential to contribute to the field.

Sexual Intervention Self-Efficacy

This section will outline the theoretical framework that contributes to the construction of sexual intervention self-efficacy. First, this section will explain the social learning and social cognitive theories at the core of self-efficacy. This section will then define self-efficacy and counseling self-efficacy. Finally, this section will operationalize sexual-intervention self-efficacy and review the literature pertaining to this construct in relationship to willingness to initiate sexual-based health discussions with clients.

Social Learning Theory

The concept of social learning was pioneered and first introduced by Holt and Brown (Holt, 1931). They examined the psychological needs of animals in relation to their behaviors.

Their study affirmed that through observations, animals were able to mimic other animals' behaviors. The construct of imitation was developed and through their research extrapolated that individuals cannot learn to mimic, or imitate, without being imitated themselves (Holt, 1931). Imitation, a socially-motivated factor, has been found to be essential in learning (Holt, 1931; Miller & Dollard, 1941). Miller and Dollard (1941) reported that environmental cues promoted individuals to engage in a behavior that they labeled as modeling, and they further articulated that for every behavior, there is an outcome. They further stated that individuals who are motivated by the same outcome will likely engage in matching behaviors to achieve the same outcome (Miller & Dollard, 1941). The actual consequences to these imitations will reinforce whether that individual will learn or reject this behavior. This process of imitation is a mechanism of drive, or motivation, that was further constructed by Miller and Dollard (1941) in their work on social learning. Miller and Dollard (1941) delineated four factors that contributed to learning that include drives, cues, responses, and rewards. In an extension of Miller and Dollard's (1941) work, Bandura (1963) examined aggression in relationship to imitation and learning. Bandura (1977) challenged operant conditioning (Skinner, 1948), and suggested that behavioral change based solely on conditioning, without consideration of the cognitive processes underlying action and consequence, was not sufficient. His initial investigations into the theory of social learning delineated the concept of self-efficacy, positing that individuals process and synthesize feedback from consequences, over long periods of time, creating patterns of thinking or beliefs about these schedules of reinforcement, which in turn then influences their behaviors (Bandura, 1977).

Social Cognitive Theory

Bandura (1977) advanced the theory of social learning by proposing that individuals do not solely learn by the condition of reinforcement, rather, they think about the relationship between stimuli and responses, and this mediating process determines whether a behavior is acquired or not (Bandura, 1977). This advancement contributed to the emergence of the social cognitive learning theory. Bandura (1986) also developed the concept of triadic reciprocal causation (Bandura, 1986), positing that human behavior, the environment, and personal factors are interrelated and interact by self-referent thought, or self-efficacy beliefs. Particularly, by observing the consequences of the behaviors of others, individuals can self-reflect, self-organize, and exercise their locus of control in the regulation of adaption and change (Bandura, 1997). As individuals perform tasks successfully, their self-referent thought makes positive associations to these behaviors, therefore creating behavioral change (Bandura, 1977). This concept emerged as the theory of self-efficacy.

Self-Efficacy

Social learning theory posits that acquisition of competence and skill are achieved through observation and social experiences. Social cognitive theory conceptualizes that the development of personality occurs through observational learning and social experiences. The theory of self-efficacy works at mediating these processes of developing competence and translating it to action. Self-efficacy is described as “the exercise of human agency through people’s beliefs in their capabilities to produce desired effects by their actions” (Bandura, 1997, preface vii). Human agency highlights the personal control an individual has to exercise self-determination and mastery of their human functioning. The core mechanism that draws this human agency into action are the beliefs that an individual has in succeeding (Bandura, 1997, p.

2). Self-efficacy is “beliefs in one’s capabilities to organize and execute the courses of actions required to produce given attainments” (Bandura, 1997, p. 3), creates the capacity an individual has in engaging in action or not, the effort put forth, the duration and frequency of action engagement, the resiliency for adversity, the thinking about the action, the adjustment and adaption to environmental demands, and the determination to be successful (Bandura, 1997). Bandura’s (1997) theory of self-efficacy can be understood in that just because an individual possess skills and competence, does not necessarily mean they will successfully perform a task, but rather, certain psychological processes are necessary to translate skills and competence into action (Bandura, 1982; Bandura, 1997, p. 37); beliefs about one’s efficacy facilitate this translation. From social learning and cognitive theories, self-efficacy mediates an individual’s approach to or avoidance of tasks, and the success in learning and developing skills. Bandura’s (1977) theory of self-efficacy advanced the field of education and psychology by demonstrating the powerful effect that self-efficacy beliefs have on the processes of how individuals change behavior and adjust their arousal.

Bandura (1997) posited that there are four factors contributing to the construction of an individual’s self-efficacy. These four factors include mastery experiences, vicarious experiences, verbal persuasion, and physiological and affective states (Bandura, 1997).

Mastery experiences. The most powerful of the mechanisms for enhancing self-efficacy is the actual enactment, or mastery experience (Bandura, 1982; Bandura et al., 1977). An individual’s beliefs at the commencement of an action about whether or not they will execute the skill successfully will factor into the effort they allocate to the task, endurance when challenged, and the response to adversity during the task. If an individual is confident in their ability to complete an action, they will elicit more effort, endure challenges, and overcome barriers more

successfully, therefore they are more apt to master the task (Bandura, 1997). Once an action is mastered, the cognitive processes linking behaviors to accomplishment leads to enhancement of self-efficacy, further perpetuating successful performances in the future.

Vicarious experiences. Another factor acting as a mechanism for generating self-efficacy beliefs includes the observation of others' mastering skills. Engaging in the same social cognitive learning processes that mediate the relationship between behavior to outcome, through witnessing the actions of other's and the qualities of those behaviors that lead to favorable or unfavorable outcomes also influence a belief of and individual's capacity to imitate the behavior (Bandura, 1977, 1986). The principles of social learning and drive to imitate will lead to increased self-efficacy, especially as the individual identifies with similar qualities of the individual being observed (Bandura, 1977).

Verbal persuasion. Although this mechanism, on its own, is not sufficient enough to produce the same self-efficacy beliefs as mastery or vicarious experiences, verbal persuasion is a useful supplement to enhance skill development. Simply defined, verbal persuasion is the feedback that an individual receives about their capacity to perform a behavior (Bandura, 1977, 1997). Typically, verbal persuasion elicited by an individual in the position of an educator or a supervisor, who is seen as experienced and competent, is the most influential to the student or supervisee's development of self-efficacy. The individual is encouraged to believe that they can effectively cope with the consequences of the identified action.

Physiological and emotional states. Arousal is the physiological or psychological responses to stimuli and plays a significant role in the associations that individuals make to interactions with their environment or people in their environment. The implications of this arousal could influence an individual's beliefs in whether they have the capacity for action.

Stress-provoking situations can induce automatic physiological responses that are unpleasant, including shaking, increased heart rate, nausea, dread, pain, and tightness in the chest, leading individuals to potentially perceive these responses as indicators that they may not have the capacity to perform effectively with the situation at hand. However, if situations are met with more pleasurable responses, such as positive affect, then individuals might believe they are more capable in completing a task successfully, therefore increasing motivation, and resulting in more willingness to engage in a behavior. Hence, physiological responses can either hinder or enhance an individual's self-efficacy. This fourth factor of generating self-efficacy can come full circle when the individual masters the action (Sousa, 2018).

Counseling Self-Efficacy

When extending the theory of self-efficacy to counseling, it is with the same mechanisms that therapists will generate their beliefs about performing counseling skills. Therapists are expected to be multifaceted, integrating cognitive, behavioral, and social skills to a course of action in order to manage varying situations in the counseling session (Larson & Daniels, 1998). Counseling self-efficacy is thought to be an important construct in mediating this competence to performance (Bandura, 1982, p. 122; Larson & Daniels, 1998). Not only are therapists expected to engage in multiple subskills demonstrating their competence, but at another level, their judgment endorses these operative capabilities (Larson & Daniels, 1998). Self-efficacy is concerned with these judgments, or beliefs an individual has about how well they can perform these tasks. Counseling self-efficacy is defined as "one's beliefs or judgments about her or his capabilities to effectively counsel a client in the near future" (Larson & Daniels, 1998, p. 180). It is considered a vital aspect of counselor training, as it deals with the development of skills, whether or not therapists will take those skills into action, and the effectiveness of that action.

Translating the theory of self-efficacy to therapy, it can be assumed that therapists would use their capacity for cognitive processes to make informed decisions about potential dilemmas and be able to prepare for them (Larson & Daniels, 1998).

Extensive research has examined counselor self-efficacy, and its relationship with related constructs such as outcome expectancies. Correlational studies have reported that proximal counselor characteristics (i.e., those not considered stable, beyond age, sex, ethnicity, and personality) have been shown to have the strongest relationship with counselor self-efficacy. Of these findings, the strongest correlations, or predictor variables include the perceptions that counselors have of their fraudulence, or feelings of being an imposter in the field (Alvarez, 1995), ratings of their self-concept (Larson et al., 1992), and anxiety. These findings have been consistent with most correlational studies exploring the relationships of counselor self-efficacy and counselor characteristics. That is, the self-mediating mechanisms of a MHCP have been reported to play a more significant role when compared to demographic variables. Through examination of self-efficacy and performance accomplishments, it can be suggested that therapists with higher self-efficacy will have higher counseling skill performance (Bandura, 1997; Miller & Byers, 2008). Further, Miller and Byers (2008) reported that MHCPs who demonstrated high self-efficacy beliefs, also demonstrated an increased willingness to perform a therapy task.

Sexual Intervention Self-Efficacy

MHCPs typically receive generalized counseling training throughout their counselor preparation programs and do not receive specialized skills training needed for specific concerns with which clients might present. From this research we can predict that when clients present with specific problems that challenge a MHCP’s competence, MHCPs can become distressed.

An individual's appraisal of their physiological and emotional states has been shown to predict an increase or reduction of self-efficacy and can be shaped by other factors including difficulty of tasks, time and effort spent on task, and outcomes of the tasks (Bandura, 1997). A therapist that is challenged by a new task will be impacted by the beliefs they have about their confidence in performing the task successfully. Sexual issues are a subset of therapeutic presentations that most MHCPs have not encountered in their graduate education or training, yet, contribute to a high prevalence of psychological concerns presented by clients. MHCPs will likely encounter clients who have sexual concerns and the role that self-efficacy beliefs play in whether a therapist intervenes successfully or not is clearly an important factor. A therapists' confidence to appropriately address sexual concerns with their clients relates to what Miller and Byers (2008) constructed as sexual intervention self-efficacy. Prior to their work in 2008, sexual intervention self-efficacy had not been extensively investigated (Miller & Byers, 2008). Miller and Byers (2008) posited that therapists would be more able and willing to examine sexual concerns with clients if they believed they could. Miller and Byers (2008, p. 138) described components of having high sexual intervention self-efficacy which included "confidence in an individual's ability to treat clients with sexual concerns, to relay accurate sexual information, and to exhibit comfort and a lack of bias when discussing sexual issues." Several variables including sex education and training (Miller & Byes, 2008; 2012), licensure type and gender (Hayes, 2019), and graduate program accreditation type (Walenz, 2011) have been shown to have a relationship with sexual intervention self-efficacy. Given the dearth of investigations about sexual intervention self-efficacy, and the consistent literature demonstrating a relationship between anxiety and self-efficacy (Bandura, 1956; 1997; Koth. 2019), this study will explore the

relationship between anxiety, sexual intervention self-efficacy, and willingness of MHCPs to discuss sexual issues with clients. (Barbee et al., 2003; Lewandowski, 2019).

Anxiety

This section will describe the constructs of state anxiety and trait anxiety that are the identified independent variables in this study. First, this section will define anxiety as it relates to MHCPs and provide a theoretical foundation for the constructs reviewed later. This section will then outline the literature pertaining to anxiety and the significance this variable has to sexual intervention self-efficacy and willingness to initiate sexual based health discussions with clients.

The construct of anxiety is complex. The diagnostic explanation of anxiety by the *Diagnostic Statistical Manual of Mental Disorders, 5th edition* (DSM-5) is that it is defined as an experience of physiological and emotional arousal that instinctually triggers an individual to respond to the perceived threat that provoked the individual (APA, 2013). This description posits that anxiety is a biological component to human survival. Other explanations view anxiety as psychological or environmental components, that create pathology (Bandura, 1983; Larson & Daniels, 1998).

Freud (1924) first attempted to explain anxiety as neurosis, by operationalizing it as "something felt," which he further described as "all that is covered by the word 'nervousness." Physiological symptoms that were found to manifest during this phenomenon included heart palpitations, respiratory disturbances, sweating, tremors, and vertigo (Freud, 1924). Freud later (1936, p. 69) distinguished anxiety from other affective states, such as anger, grief, or sorrow, further identifying phenomenological feelings of apprehension and dread. However, the focus became the antecedents to the state of anxiety, and on developing theoretical formulations for what sources contributed to the precipitated anxiety (Freud, 1936, p. 20). Early theories included

the repressed libido, suggesting that the inability to express sexual tensions would be built and transformed into anxiety (Freud, 1936). Later formulations described anxiety as a signal to the individual of danger, and the type of anxiety was differentiated between whether the source was from interactions with the external environment or from internal impulses. These constructs were defined as objective anxiety and neurotic anxiety.

Mowrer (1950) proposed an alternative theory to Freud's (1936) theory of anxiety, defining anxiety as ". . . comes, not from acts which the individual would commit but dares not, but from acts which he has committed but wishes that he had not," demonstrating a theory related to guilt and conscience rather than instinct (p. 537). Sullivan (1953, p. 41) promoted another theory of anxiety, explaining that it arose from interpersonal relationships and the experience of disapproval. An individual's reality becomes distorted when aroused, as they filter information from the stimuli inaccurately because of blocking disapproved personality traits. In addition, May (1950, p.191) much like Freud (1936) suggested that anxiety was innate, and reactions to objective danger could be proportionate or disproportionate, explaining fear as a learned response.

State and Trait Anxiety

Spielberger (1966) explored these theories of anxiety and proposed it to be a complex response that elicits a state or condition that fluctuates in intensity, frequency, and duration. Conceptual formulations and the distinction between state and trait anxiety was first examined by Cattell and Scheier (1961) utilizing factor analysis. The state anxiety factor was found to include a transitory state or condition that varied and fluctuated over time and included physiological signs of arousal. The trait anxiety factor, however, was reported to be comprised of stable individual differences within an enduring personality characteristic. Following this work,

anxiety was viewed as a transitory state and as a personality trait that was empirically investigated by many theorists. Spielberger (1966) presumed it meaningful to distinguish the two concepts, developing the initial investigative work on trait-state anxiety. Anxiety states (A-state) were characterized as ". . . subjective, consciously perceived feelings of apprehension and tension, accompanied by or associated with activation or arousal of the autonomic nervous system" (Spielberger, 1966, p. 17). While anxiety traits (A-trait) were characterized by:

> . . . a motive or acquired behavioral disposition that predisposes an individual to perceive a wide range of objectively nondangerous circumstances as threatening, and to respond to these with A-state reactions disproportionate in intensity to the magnitude of the objective danger (Spielberger, 1966, p. 17).

Spielberger's (1966, 1972) model of state and trait anxiety described a temporal process of experiencing anxiety with an interplay of interacting internal and external stimuli, cognitive factors, and defense mechanisms. The model posits that an individual with an anxious state will be physiologically aroused by an external stressor or internal cue that goes through a cognitive appraisal process to determine the threat. The threat then activates defenses to overcome the fear (Grös et al., 2007). An individual demonstrating trait anxiety chronically and pathologically engages in a reflection of these past anxious states, registering these experiences as threatening, increasing proneness or sensitivity to future anxious states. The *State-Trait Anxiety Inventory* (STAI; Spielberger, 1983) was developed to measure and assess an individual's state anxiety (S-Anxiety; Form Y-1) and trait anxiety (T-Anxiety; FormY-2). The STAI has been empirically evaluated extensively, appearing in over 3,000 studies and has been translated to over 30 languages (Spielberger, 1989), demonstrating its utility in psychological research. This measure

will be further discussed in chapter three as it will be used in this study to measure state and trait anxiety among MHCPs.

MHCP Anxiety

Anxiety may arise during a discussion of sexuality, triggered by the explicit sexual material. This anxious distress could impact the behaviors of the MHCP due to creating an environment that the MHCP wants to neutralize, leading to minimizing or avoiding behaviors (Harris & Hays, 2008). Due to the interpersonal nature of psychotherapy, a MHCP's personality traits, such as anxiety, were viewed as an important variable in the determination of counseling effectiveness (Bandura, 1956; Bandura et al., 1960). Bandura (1956) discussed the imperative role that the personality characteristics of the psychotherapist are assigned in the treatment process, and further proceeded to investigate the relationship between the therapist's anxiety level, the degree of self-insight into their anxieties, and their competence in providing effective psychotherapy. Bandura (1956) evaluated 42 psychotherapists, of which were 32 were clinical psychologists, eight psychiatrists, and two psychiatric social workers, as participants in this study. The participants represented varying clinical settings, including a community psychological clinic, a university counseling center, and a V.A. neuropsychiatric hospital. Measures of anxiety and insight were obtained for three central conflict areas including dependency, hostility, and sexuality. For each area of dependency, hostility, and sexuality, anxiety was measured by observing and rating the psychotherapist's descriptive statements and overt behaviors (rated low, medium, or high degrees of anxiety) by fellow participants, as well as their own self-rating in a designated group. Subsequently, each therapist received a ranking in their group, determined by the assessment of who was the most anxious to who was the least anxious. These rankings within each group were standardized with a mean of five and standard

deviation of two. These scores constituted the ratings for data analysis. Insight was defined as the relative discrepancy between a subject's self-rating and the average group rating, which was essentially the group rating minus the self-rating. A participant who rated themselves equal to or higher than the group rating, was considered to be aware of their anxieties. Therefore, if a participant rated themselves lower than the group, they were considered to have low insight. Competence was measured by thirteen selected supervisors that were distributed to the different groupings, that ranked the therapist's ability to facilitate improvement in the adjustment of the patients. The supervisors assessed their designated groups by the most competent therapists to the least competent, which received a rank of one. These rankings were also standardized, with a mean value given to each therapist. The final composite score served as the criterion measure. Reliability of competence scores was analyzed using the Ebel (1951) technique, finding the coefficient of reliability for the sample to be .84. The therapist's rating for each other were analyzed using Horst's (1949) generalized reliability formula for each group, as the raters were not the same for all participants. The reliability coefficients for the group were .82 for dependency, .86 for hostility, and .82 for sexuality. Bandura (1956) reported that there was no reliability measure for insight. Following Pearson's product-moment correlation analyses, anxiety measures in each of the areas of adjustment, dependency, hostility, and sexuality, were significantly correlated with the criterion measure, psychotherapeutic competence. The corresponding multiple correlation showed a magnitude of -.68 ($p < .01$), which demonstrated an inverse relationship between anxiety and therapeutic competence. This suggests that higher ratings of therapist's anxiety were related to lower ratings of therapist's competence. Bandura (1956) interpreted this finding as suggesting that a therapist's personality (anxiety) may facilitate or impede their attempts to apply therapeutic procedures. The results failed to demonstrate any

relationship between self-ratings of anxiety and psychotherapeutic competence, as well as between insight and competence. This finding could suggest that self-ratings of anxiety may accurately depict an individual's estimate of their anxiety, or might signify poor insight, making these variables difficult to interpret. Given the relationship found between anxiety ratings and psychotherapeutic competence, Bandura (1956) suggested the importance of further examination into the way in which anxiety affects a therapist's psychotherapeutic work. Following this assertion, Bandura and colleagues (1960) proceeded to examine anxiety tendencies of approach-avoidance behaviors in therapists dealing with emotionally charged material.

Bandura and colleagues (1960) specifically examined the adjustment area of hostility, asserting that hostility conflicts tend to be present to some degree in all patients. In this study, 17 parents who were receiving psychotherapy at a parent-child clinic were recorded in their sessions. This constituted 110 randomly selected interviews with 12 different therapists (10 males, 2 females) providing psychotherapy. Therapists in training were the providers of services in this study. The personality characteristics (approach-avoidance tendencies) of the 12 therapists were measured by independent ratings from four staff members who had extensive social and professional contact with them. The ratings were provided on eight five-point rating scales. Hostility anxiety was measured three ways, including direct hostility displays, indirect hostility displays, and hostility inhibition. The therapists were also rated on dependency behavior, including help seeking, approval seeking, and dependency inhibition. These measures were conducted by two judges who coded 20 randomly selected interviews of the 110 interviews. The scoring units were the interaction sequences that started with a patient statement, then a therapist's response, and finally a patient's response. The patient's hostility responses were defined by any expression of dislike, resentment, anger, antagonism, opposition, or of critical

attitudes. The therapist's responses were divided into either an approach reaction or avoidance reaction. Approach reactions were defined as intentions to elicit hostile expressions from patients and include approval, instigation, reflection, and labeling. Avoidance reactions were defined as responses that inhibit, discourage, or divert hostile expressions from patients and include disapproval, silence, ignoring, and mislabeling. Unclassified reactions were also identified and included nonscorable utterances and irrelevant responses. Reliability of hostility anxiety was assessed by the degree at which judges agreed. Inter-judge agreement in coding responses of 4734 interaction sequences found perfect agreement among 261 units scored, minor discrepancies among 100 units scored, and disagreement in 37 units scored. Reliability for therapists' personality characteristics was estimated by Ebel's (1951) analysis of variance technique. Reliability coefficients were found for direct hostility, indirect hostility, hostility inhibition, help seeking, approval seeking, dependency inhibition, sex inhibition, and warmth, ranging from .69 to .86. Differences in therapists' personality characteristics and their relative frequency of approach or avoidance interventions were evaluated. One statistically significant difference was found between the two groups, which was that the therapists who expressed more direct hostility were more likely to respond with approach reactions when patients expressed hostility toward extratherapeutic objects than those who expressed low direct hostility. No differences were found between the two groups when therapists were the object of the patients' hostility. Of the remaining personality measures, only one demonstrated a relationship with the therapists' hostility responses. Those therapists that displayed a high need for approval were more likely to express avoidance reactions, whether the object of patients' hostility was directed towards the therapist ($p < .06$) or toward others ($p < .002$), than therapists who were rated low on the approval seeking scale. Specific reactions that contributed to the overall differences were

evaluated and results indicated that therapists who expressed more direct hostility were more likely to ignore patients' hostility ($p < .03$). Additionally, therapists who were rated high on the approval seeking scale demonstrated more responses that ignored patients' hostility ($p < .004$) and were more likely to change the discussion to nonhostility based responses ($p < .02$) than therapists who displayed low approval seeking behaviors. The results of Bandura and colleagues' (1960) study could suggest that anxiety tendencies and personality characteristics could impact the way in which MHCPs respond and handle clients that demonstrate conflict areas of adjustment, which include hostility, dependency, and sexuality.

Yulis and Kiesler (1983) further examined the assumption that topics of sex and aggression are more likely to evoke conflict in therapists by exploring anxiety-defense manifestations conceptualized as countertransference in relation to their interactions with clients. Twenty-four graduate students in clinical psychology and education counseling at the University of Iowa were first divided into two groups of high-anxious and low-anxious therapists. Anxiety was measured by two judges assessing a five-minute script recorded by each of the therapists that tasked them to talk without interruption about any interesting or dramatic life experience. The judges utilized Gleser and colleagues' (1961) anxiety scale that attempts to measure "free" anxiety and includes only the psychological manifestations of anxiety, not the physiological manifestations of anxiety. A high level of inter-judge reliability was demonstrated ($r = .98$). The median of scores was used to divide the two groups. Each therapist was provided one of the three client tapes that included sexual, hostile, or neutral content. They were asked to make interpretive statements following prompts in a booklet. Following a 2x3 analysis of variance among high- versus low-anxiety therapists and sex versus aggressive versus neutral patient-tapes, results showed that there was only one significant effect which was that of therapist anxiety level

($F = 4.958$, $df = 1/22$, $p < .05$). This main effect indicated that low-anxious therapists showed less countertransference (irrationality as a result of anxiety and defense) in their responses to the patients' tape recordings. Yulis and Kiesler (1983) suggested that these findings were consistent with Bandura (1956) and Bandura and colleagues (1960), in that, within the psychoanalytic framework of this study, anxiety affects a therapist's ability to perform successful therapy. Further consistencies from the findings of this study with the research of Bandura also include confirmation that highly anxious therapists are more inclined to avoid patient's hostile feelings. However, Yulis and Kiesler (1983) determined that this avoidance response can be generalized to expressions of sexuality, aggression, or neutrality by the patient.

A MHCP's emotional response, anxiety or discomfort, could certainly be triggered by threatening stimuli, such as discussions of sexually explicit material. However, anxiety in a MHCP may also be triggered by the presence of client anxiety, who may be fearing sexuality discussions (Bandura et al., 1960). Thus, MHCPs that experience anxiety with anxious clients may be distracted by their emotional response, lose sight of the relationship process, and further perpetuate the cycle of anxious avoidance (Harris & Hays, 2008).

Anxiety and Self-Efficacy

The relationship between self-efficacy and anxiety has been described as a motivating force rather than debilitating one, allowing an individual to exercise control over their interpretations of their environment and situations (Bandura, 1977; 1993; Larson, 1998). By exploring the negative impact that anxiety has on performance, research has demonstrated that lower levels of anxiety are associated with higher levels of counselor self-efficacy (Bandura, 1977). Bandura's (1983) theory of self-efficacy advances that individuals who perceive themselves as ineffective in their ability to cope with potentially aversive events (i.e., self-

efficacy evaluations), can generate fear (Bandura, 1983). In contrast, if individuals have beliefs about their ability to exercise control over aversive events, they do not fear them.

Several researchers have attempted to evaluate the relationship between self-efficacy and anxiety and how this potential relationship might impact whether a MHCP would engage in conversations about sexual concerns with clients. For example, Miller and Byers' (2008) explored the relationships between several independent variables; including sexual intervention self-efficacy, sex anxiety, and sexual attitudes, and the dependent variable of willingness to initiate discussions with clients about sexual problems and concerns, among psychologists. These researchers investigated predictor variables related to sexual intervention self-efficacy using a multiple regression analysis (Miller & Byers, 2008). These researchers reported that there was no relationship between sexual anxiety and sexual intervention self-efficacy, despite the literature affirming the role of anxiety in the development of self-efficacy (Bandura, 1997). While surprising, it was discussed that the sex anxiety measure was associated more with a participants' feelings of their own sexuality, instead of assessing anxiety as it pertains to dealing with clients' sexual problems and concerns. It was further suggested that general anxiety may be more significantly correlated than sexually specific anxiety (Miller & Byers, 2008). The authors suggested that future research should examine the relationship of anxiety with discussing clients' sexual experiences.

There have been additional empirical studies that have supported the relationship between anxiety and counseling self-efficacy in the exploration of state and trait anxiety (Daniels, 1997; Friedlander et al. 1986; Larson et al. 1992). However, most studies have measured state anxiety due to self-efficacy being an immediate, present-centered cognitive appraised (Daniels & Larson, 2001).

Daniels (1997) investigated the impact of bogus performance feedback on causal attributions and counseling self-efficacy. Forty-five students in counseling and related graduate programs enrolled at four midwestern universities were asked to complete pretest measures, then conduct a ten-minute mock counseling session. Following the session, participants rated themselves, completed the S-Anxiety scale of the STAI, received random, bogus success or failure feedback, and then asked to compete post-test measures. The pre- and post-test measures assessed counseling self-efficacy, causal attribution, and state anxiety, with performance feedback being the independent variable. The Counseling Self-Estimate Inventory (COSE; Larson et al., 1992) assessed the participants self-perceptions of their capability to execute counseling activities successfully during a counseling session. The S-Anxiety scale of the STAI was administered to participants to measure anxiety. Although this examination was intended to investigate the differences before and after receiving performance feedback, the researchers reported a significant negative correlation between pre-test and post-test measures on both the COSE and STAI S-Anxiety scale. Meaning, the higher the participants self-rated on counseling self-efficacy, the lower the ratings of state anxiety. In a regression analysis to investigate predictors of post-test counseling self-efficacy, results revealed that pre-test counseling self-efficacy, performance feedback, and post-test anxiety were all significant predictors to increased beliefs that participants had about their capability to effectively perform counseling tasks.

Kocerak (2001) reported similar findings in their exploration of relationships between counseling self-efficacy, anxiety, developmental level, coursework, experience, and counselor performance among 117 master's student counselors at three levels of training. The participants were asked to complete the COSE, STAI, and Supervisee Levels Questionnaire – Revised (SLQ-R). The participant's supervisors completed the Counselor Evaluation Rating Scale (CERS). A

hierarchical regression procedure was conducted to determine if there were predictor variables of counselor performance. Included in the three step regression equations were the three completed measures, as well as the amount of paraprofessional counseling experience and number of counseling courses to predict counselor performance. A correlation matrix revealed a statistically significant inverse relationship between the COSE (counselor self-efficacy) and the STAI (anxiety) at $r = -.55$ ($p \leq .05$). Therefore, the higher the scores on the STAI, which indicated higher anxiety were associated to lower scores on the COSE, which indicated lower counseling self-efficacy. Several other studies corroborated this empirical evidence demonstrating an inverse relationship between counseling self-efficacy and anxiety (Barbee and colleagues, 2004; Larson & Daniels, 1998), which provided further support for social cognitive theory, in that, physiological arousal has been shown to contribute to levels of self-efficacy (Bandura, 1977).

Willingness to Initiate Sexual-Based Health Discussions with Clients

This section will operationally define the dependent variable willingness to initiate sexual-based health discussions with clients. This section will also review the literature pertaining to the barriers and predictors of this outcome behavior providing a rationale and justification for this study.

Sex has been generally stigmatized and considered taboo (Wilson, 2017) in the US, with roots in emotions such as shame and embarrassment. Sexually-based topics can provoke discomfort, which may leave MHCPs avoiding or dismissing discussions that are necessary with clients who may present with sexual health concerns. In fact, the literature has indicated that some MHCPs rely on the client to initiate discussions of sex and sexuality (Wilson, 2019). Miller and Byers (2012) reported that a *willingness to initiate sexuality discussions* has been demonstrated by a MHCP who has increased acceptance with taking on client concerns in

counseling, rather than referring, has a greater likelihood of engaging in more inquiry regarding sexual concerns or difficulties during assessment, and will demonstrate increased behaviors that address and treat sexual concerns in therapy. This explanation then suggests that there are behaviors implemented throughout the counseling process on the part of the MHCP that demonstrate a willingness to initiate, address, inquire, and treat client sexuality concerns.

Many variables have been explored to explain what impacts a MHCP's failure to initiate discussions about sexual concerns with clients. However, there have been few studies that have examined willingness to initiate sexuality discussions with clients as the dependent variable.

Arnold (1980) examined CITs to investigate the relationship between completion of a human sexuality course, affective arousal of the counselor a sexual human being, and sexual knowledge and experience, and willingness and comfort to address sexual concerns with clients. Sixty-eight students that were enrolled in a graduate level counselor training programs at the University of Northern Colorado were administered instruments that measured each of the variables. The research was the first to construct a measure for counselor willingness to deal with clients' sexual concerns or counselor comfort, which was the Client Sexual Concern Check List (CSCCL; Arnold, 1980) consisting of two subscales, the "willingness to counsel" and "counselor comfort" and was utilized to measure the dependent variable. The study was conducted utilizing a posttest-only control group, experimental design. Participants were randomly placed in the treatment group or control group, with the difference being the order of which they took the instruments. The control group was directed to complete the CSCCL first, while the treatment group was to complete the instrument last, as the CSCCL was the dependent variable. The other two instruments, the Sex Knowledge and Attitude Test (SKAT; Lief & Reid, 1972) and the Psychology Today Sex Survey (PTSS; Athanasiou & Shaver, 1969) were administered to

measure sexual attitudes, sexual knowledge, and sexual experience of helping professionals, and sexual habits, sexual experience and attitudes, and demographic characteristics, respectively. Both instruments were independent variables for the treatment group and were utilized to collect survey data for the control group. The rationale for administering the two instruments prior to completing the CSCCL was that they would create an affective arousal, and if so, the effects of this reaction would be measured by the CSCCL. Differences between groups was surprising, in that, the mean score for the "Comfort" scale on the CSCCL was significantly higher for the control group than the treatment group ($t(33) = 2.31$, $p < .01$). This indicated that the effects of the independent variable overcame any advantage that the treatment group had, which included the fact that those participants who had completed a counseling practicum experience; and, those that had a counseling practicum experience tended to score higher on the CSCCL than those who did not. Arnold (1980) reported that the mean score on the "Willingness" scale of the CSCCL was significantly higher for the treatment group than the control group ($t(33) = 1.92$, $p < .05$). This opposed the result of the between-groups differences for comfort, in that, those in the treatment group were reported to have more counseling practicum experience; further, those with more counseling practicum experience had higher "Willingness" scores than those who had not taken the counseling practicum. However, it is reported that the "Willingness" scale of the CSCCL was skewed towards higher scores, demonstrating that there was not a normal distribution, and should be considered with caution. Further analyses revealed several significant relationships between the variables and the therapists' willingness to discuss sexual concerns with clients. This included a significant positive correlation between the "Knowledge" scale of the SKAT and "Willingness" scale ($r(66) = .31$, $p < .05$), and the "Attitudes" scale of the SKAT and the "Willingness" scale ($r(66) = .30$, $p < .05$). Between-group differences in various attribute

categories among participants were examined, and a significant effect was reported for participants that had completed a graduate level course in human sexuality such that those participants demonstrated significantly higher scores on the "Willingness" scale of the CSSCL ($t(66) = 1.68$, $p < .05$). Due to the differences of relationships between the "Comfort" and "Willingness" scales of the CSSCL and other variables analyzed in this study, it could be suggested that a MHCP does not have to be comfortable with engaging in a discussion about sexual concerns in order to be willing to do so.

In the last hallmark study, Harris and Hays (2008) investigated the dependent variable of marriage and family therapists' initiation of sexuality discussions with clients through the examination of factors that were thought to be influential. This study has been extensively cited in subsequent research that also examined variables that influence whether or not MHCPs are having sexuality discussions with their clients. One hundred and seventy-five clinical members of the American Association for Marriage and Family Therapy (AAMFT) were surveyed to assessed how their clinical training, perceived sexual knowledge, and comfort with sexual material influenced their willingness to engage in sexuality-related discussions with clients. The researchers used a path analysis model to investigate the relationships between the independent variables sexuality education and supervision experience with sexual issues, clinical experience with sexual issues, perceived sexual knowledge, and sexual comfort; and, the influence that these independent variables may have on therapists' willingness to initiate sexuality discussions with clients. Background variables including gender, age, values, education, area of discipline, years in practice, and average number of clients per week were also examined in post hoc analyses. The first regression analysis indicated that therapist sexuality education and supervision experiences with sexual issues, and clinical experience with sexuality issues explained 27% of

the variance in the therapists' perceived sexual knowledge. The second regression analysis suggested that the variables of the first regression, and included perceived sexual knowledge explained 48% of the variance in therapist comfort with sexuality matters. The final regression indicated that the former three variables and included therapist comfort with sexuality matters explained 33% of the variance in therapists' initiating sexuality discussions with their clients. Perceived sexual knowledge did not have a significant direct effect on therapists' initiation of sexual discussions with clients. The findings rejected the therapists' hypothesis that perceived sexual knowledge would more likely influence initiation of sexuality-related discussions with clients. Total direct and indirect effects of each variable showed that sexuality education and supervision experiences (r = .37) had the greatest influence on therapists' initiating sexuality discussions with their clients. The second largest overall effect on sexuality discussions was therapist comfort with sexual content (r = .31). The second largest direct influence on therapist-initiated sexual discussions was sexuality education and supervision experiences. This indicated that sexuality education and supervision experiences with sexuality issues and sexual comfort are the best predictors of therapists' initiating sexuality-related discussions with their clients. Therapist clinical experience with sexual issues had a close significance at p =.08. Following the post hoc analyses, it was reported that age, gender, discipline, or years of practice did not affect the influence that the predictor variables of sexuality education and supervision relationship had on therapists' comfort with sexual content and discussions with clients about sexuality issues. Perceived sexuality knowledges showed the largest indirect effect, which suggested that the more sexuality education and supervision related to sexuality issues a therapist has, the more they perceive themselves as knowledgeable about sex, and the more comfort they have with sexual matters. The theoretical framework of Harris and Hays' (2008) utilized the Bowen family

systems lens to examine the construct variables. Therefore, the lack of finding a direct influence of perceived sexual knowledge on sexuality discussions contradicted the Bowen perspective that achieving greater degrees of intellectual differentiation, in this case, perceived sexual knowledge, would automatically lead to less anxiety. The researchers asserted that sexual knowledge without comfort is not enough for therapists to initiate sexual discussions with their clients.

Cupit's (2010) study was based on and extended the work by Harris and Hays (2008), in that, he also examined many factors that may influence counselors' sexual comfort and their willingness to discuss sexual issues with the couples that they counsel. The variables the researcher specifically investigated included sexual comfort, sexual attitudes, training experience in discussing sexual issues, sexual knowledge, supervision experience addressing sexuality, clinical experience discussing sexual issues, sex, age, strength of faith, sexual orientation, number of years practicing, practice setting, type of license, type of graduate specialization, and relationship status. The researcher surveyed 224 members of the American Counseling Association (ACA) consisting of varying licensing statuses (LMFT, LPC, LPCC and LMFT, not licensed, other) and worked with couples. Correlational analyses were calculated to investigate whether relationships existed between the independent variables and participants' willingness to initiate sexuality discussions with couples. A significant negative relationship was found between participants' sexual comfort, as measured by the score on the Sexual Comfort Instrument (SCI; Hedgepeth, 1988), and participant's discussions of sexual issues with couples, as measured by Sexuality Discussion with Clients Scale (SDCS; Harris & Hays, 2008), (r = -.40, p < .01). The scores on the SCI were reverse coded, which indicated that the lower the score, the greater the sexual comfort. This relationship then demonstrated that the greater the sexual comfort, the greater willingness counselors have to initiate sexuality discussions with couples.

Participants' sexual comfort explained 16% of variance in the extent to which counselors discuss sexual issues with couples. Significant relationships were also found between both a participants' graduate work specializations (addiction, career, clinical mental health/community, marriage, couple, and family, school, student affairs and college) (X^2 = 318.7, *df* = 250, n = 202, $p > 0.01$) and a participants' age ($r = .18$, $p < .01$), and their willingness to initiate sexuality discussions with couples. More specifically, participants who specialized in clinical mental health/community or marriage and family counseling, and older participants, influenced the extent to which participants discussed sexual issues with couples. A stepwise linear regression was utilized to analyze whether one or more of the independent variables (sexual attitudes, training experience in sexual issues, sexual knowledge, supervision experience addressing sexuality, and clinical experience with sexual issues) could predict the extent to which counselors would discuss sexual issues with the couples they counsel. A significant regression equation was found ($F = 18.20$, $p < .01$, n = 190), with $R^2 = .163$. One of the two variables that were found to predict willingness to initiate sexuality discussions with couples was sexual attitude regarding birth control, explaining 14% of variance. The second variable revealed to predict willingness was influenced by supervision experience addressing sexuality issues, together with Birth Control attitudes, explained 16% of variance. The findings of this study indicated that an MHCP's age, graduate specialization, sexual comfort, sexual attitudes, and supervision experiences with sexual issues were associated with the willingness that the MHCP had in initiating sexuality discussions with clients.

Other research has examined similar factors, narrowing their research to focus on consistent trends and new variables. However, the empirical evidence has been limited. Nevertheless, some independent variables that have been shown to be related to whether a

MHCP will address or discuss sexual issues with clients or not. Those variables that have been frequently reported to relate to or predict the dependent variable have included sexual comfort (Berman, 1997; Cupit, 2010; Graham & Smith, 1984; Harris & Hays, 2008; Hays, 2002; Juergens et al., 2009; LoFrisco, 2013; Moore, 2018), sexual attitudes (Arnold, 1980; Cupit, 2010; Flaget-Greener et al., 2015; Juergens et al., 2009), sexual knowledge (Arnold, 1980; Hays, 2002; Juergens et al., 2009), educational experiences (Cupit, 2010; Fisher, 2019; Flaget-Greener, Gonzalez, & Sprankle, 2015; Harris & Hays, 2008; Hays, 2002), supervision experiences (Cupit 2010; Harris & Hays, 2008; Moore, 2018), and some demographic factors (Bloom et al., 2016; Cupit, 2010; Fisher, 2019; LoFrisco, 2013).

Variables Related to MHCP's Willingness to Initiate Sexuality Discussions

Sexual comfort. 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, education, and sexual aspects of one's being" (p. 439). This definition has been extensively cited in the sexuality counseling literature and was the basis for Hedgepeth's (1988) design of the first instrument to measure comfort with sexuality, the Sexual Comfort Instrument (SCI; Hedgepeth, 1988). The development of the SCI has provided researchers more opportunities to quantitatively investigate the construct of sexual comfort. Sexual comfort has been well examined in the counselor education literature for at least four decades, showing a significant relationship with increased sexuality discussions in counseling (Berman, 1997; Cupit, 2010; Graham & Smith, 1984; Harris & Hays, 2008; Hays, 2002; Juergens et al., 2009; LoFrisco, 2013; Moore, 2018).

Berman (1997) examined the relationships between formal and informal education, sexual comfort and agency support; and the influence that these variables have on social worker's willingness to address sexual issues with clients. Three-hundred and one social workers that belonged to the National Association of Social Workers (NASW) who had been practicing for at least one year in an outpatient mental health agency participated in this study. The participants responded to survey instruments that included Agency support checklist authored by Berman (1997), education experience authored by Berman (1997), the Personal Sexual Comfort (PSC) and General Sexual Comfort (GSC) subscales of the Sexual Comfort Instrument (SCI; Hedgepeth, 1988), and Willingness to Discuss Clients Sexual Concerns (WACSC) subscale of the Client Sexual Concerns Check List (CSCCL; Arnold, 1979). Utilizing a series of multiple regression correlation analyses, the researchers investigated relationships among the variables. Unfortunately, the measure to assess willingness of therapists to discuss sexual concerns with clients was skewed and did not meet the assumption for normativity. Instead the researcher dichotomized the data in order to run a 2 x 2 crosstabulation to test the relationship. This resulted in a relationship that significantly differed from a random distribution between sexual comfort and willingness to discuss sexual concerns with clients ($X^2 = 19.05$, $df = 1$, $p < .01$) with actual frequencies much higher than expected, supporting a positive relationship. Further analysis could not be completed to test whether the variables predicted therapists' willingness to discuss sexual concerns with clients due to skewness of the WACSC measure and did not have the normal distribution needed for regression analysis. This study was valuable in encouraging subsequent research to focus on the influential factors contributing to a MHCP's willingness to initiate sexuality discussions with clients.

Hays (2002) built upon and supported Berman's (1997) work by investigating the influence of marriage and family therapists' sexuality education, clinical experience with sexuality issues, supervision experience addressing sexuality issues, sexual knowledge, and sexual comfort about the extent to whether they were initiating sexuality related discussions with their clients. A questionnaire assessing these variables was administered to 175 clinical members of the American Association for Marriage and Family Therapists (AAMFT) who met criteria for participation. Following preliminary analysis of the data, results indicated that the sex knowledge measure, Sex Knowledge and Attitude Test (SKAT; Miller & Lief, 1979), did not serve as an adequate scale of sexual knowledge. Therefore, the SKAT was not used for analyses in the subsequent path model. However, the survey developed by the researcher to assess perceived sexual knowledge was a better fit for the model, and reportedly a better predictor of the dependent variable. Another adjustment made following preliminary analyses was to combine the sexuality education variable with the supervision experience variable due to high correlation, and inability to measure distinct phenomenon. Correlation analyses between the adjusted variables and sexuality discussions with clients showed significant relationships between all the variables, with the strongest relationship between sexual comfort and discussions of sexual issues with clients ($r = .494$, $p < .01$). Regression analyses were conducted to examine the effects of the four variables: sexuality education, supervision experience addressing sexual issues, clinical experience addressing sexuality issues, perceived sexual knowledge, and comfort with sexuality matters on therapist sexuality discussions with clients in a path model. The variables explained 33% of the variance in therapists' discussions of sexual issues with clients. A final path model showed that marriage and family therapists' sexual comfort had the largest statistically significant direct effect on therapist sexuality discussions with clients ($r = .31$).

However, sexual comfort was the second largest predictor, next to the overall direct and indirect effects of sexuality education and supervision experience (r = .37) addressing sexual issues on therapists' discussions of sexual issues with clients. Hays' (2002) work was published in Harris and Hays (2008), which vetted the findings of this dissertation.

LoFrisco's (2013) provided additional support for the influence of sexual comfort on a MHCP's initiation of sexuality discussions with clients using a mixed methods approach. This researcher examined the relationship between comfort levels in discussing sexual topics with clients and the frequency with which these conversations were initiated to individual clients versus couples, among mental health counselors. Sixty-three MHCPs, of varying professional identities, in the state of Florida, were surveyed and interviewed for data regarding their views of sexual comfort, willingness to address sexual issues, reactions to clients that raise a sexual issue, and how supervisors can assist. Utilizing a chi-square test of independence, a significant relationship was found between counselor comfort level and the frequency of initiation of sexuality discussions among individual clients, X^2 (4, N = 63) = 9.53, p < .05). However, a relationship was not found with couples' cases, X^2 (6, N = 61) = 8.96, p < .05). Cramer's V was calculated at .22 for individual cases. LoFrisco (2013) asserted that these findings supported the assumption that sexual discomfort is the barrier to MHCPs initiating sexuality discussions with their clients.

Juergens and colleagues (2009) further supported the relationship that comfort with sexuality has with rehabilitation counselors' willingness to discuss sexuality with clients. Physical disability can greatly affect the quality of sexual relationships, increase poor sexual adjustment, and impact self-esteem and body image (Hays, 2002; Juergens et al., 2009). Rehabilitation counselors may be challenged to provide sexuality-related assistance during

counseling of clients with disability. Although Juergens and colleagues (2009) focused on rehabilitation counselors rather than MHCPs, it is one of the few studies that focused on willingness to initiate sexuality discussions with clients as the dependent variable; and the results offer generalized insight into influential variables that may affect an MHCP's willingness to discuss sexuality with clients.

One hundred and sixteen master's rehabilitation counseling students from 43 rehabilitation counselor education programs in the United States completed a questionnaire that assessed their demographic background, sexuality education, attitudes toward the sexuality of people with disabilities, sexual comfort, counselor willingness to discuss sexuality with clients, and sexual knowledge. The path analysis was utilized to examine effects between the variables. Due to needing to improve the fit of the hypothesized model, the model was respecified, creating a more parsimonious model. The path analysis resulted in finding two direct effects on willingness and three indirect effects on willingness. Comfort with sexuality was found to have the strongest direct effect on willingness to discuss sexuality among rehabilitation counselors (r = .42). The goodness of fit of the respecified model was assessed utilizing a chi-square test, resulting in a nonsignificant value, $X^2 = 8.86$, $p = .115$, which suggested that the respecified model fit the data and provided a good representation of the direct and indirect influences on the variable willingness to discuss sexuality with clients. A strong positive relationship was also found between sexual comfort and willingness ($r = .500$, $p < .01$). Juergens and colleagues (2009), despite focusing on rehabilitation counselors, reported findings was supported in other research that linked sexual comfort with willingness to initiate sexuality discussions with clients of health providers (Harris & Hays, 2008; Hays, 2002; LoFrisco, 2013).

Sexual attitudes. Given the stigma surrounding sex, much of the literature has examined the impact that MHCP's sexual attitudes had on the engagement in sexuality discussions with clients. For example, Arnold (1980) conducted one of the first studies that examined the relationship between sexual knowledge, sexual attitudes, sexual comfort and willingness to discuss sexual issues with clients among counselors-in-training. The concern was that potential bias and attitudes of MHCPs could negatively impact the messages that clients received regarding sex, believing that sex is wrong, dirty, or sinful (Arnold, 1980). In this correlational study, Arnold (1980) reported a significant positive relationship between attitudes towards sex and willingness to initiate sexuality discussions with clients ($r(66) = .30$, $p < .05$). This indicated that those participants who had more liberal, or permissive, attitudes towards sex, had more willingness to facilitate conversations about sexual concerns with clients. Subsequent research investigating the influence that MHCP sexual attitudes have on their willingness to initiate discussions about sexuality with clients have mixed results. Including those that support Arnold's (1980) findings are Flaget-Greener and colleagues (2015). Concerned for the necessity to increase the quality of life of older adult patients among health providers, the researchers investigated mental health professionals' characteristics that integrated sexuality discussions into clinical practice. The researchers specifically examined predictors of practicing psychologists' attitudes towards sexual health of older adults. Further, the role of psychologists' demographic and education and training characteristics on attitudes was examined. One hundred and nineteen doctoral level psychologists licensed in the United States completed a questionnaire to assess their perceived level of competency to treat sexual and older adult-related health concerns, attitudes toward the sexual health of older adults, and willingness to assess sexual health. Two clinical vignettes were provided to the participants as a condition between the

sociodemographics and education/training questionnaire, and the attitudes measure. A forced-entry hierarchical regression was conducted to examine whether the vignettes, providers' characteristics, geropsychology and sexuality education and training, attitudes towards older adults' sexuality, would significantly predict psychologists' willingness to assess sexual health. The final path model was significant in predicting the dependent variable $F(1, 110) = 8.53$, $p = .004$, $R^2 = .07$. Results showed that permissive attitudes toward older adult's sexuality ($b = .04$, $p = .01$) was independently predictive of psychologists' willingness to assess older adults' sexual health.

Further empirical support that MHCPs who hold more liberal or permissive attitudes towards sexuality have increased willingness in initiating sexuality discussions with clients was also demonstrated in research among rehabilitation counselors. Juergens and colleagues' (2009) path analysis of factors predicted to influence willingness of rehabilitation counselors to discuss sexuality with clients showed that attitudes towards sexuality of people with disabilities had indirect effects. Like other variables examined, sexual attitudes had a direct effect on comfort with sexuality .45, which in turn, had a direct effect on willingness to discuss sexual concerns .42. This indicated that permissive sexual attitudes were reported to have an indirect influence on the extent to which rehabilitation counselors were engaging in sexuality discussions with clients.

Cupit's (2010) examination of influential factors that contributed to whether counselors discussed sexuality with couples found sexual attitudes to be a significant predictor of willingness. However, contradictory to earlier studies, it did not find that liberal or permissive attitudes related to willingness, but rather, attitudes towards responsibility and tolerance of sexuality. Cupit (2010) explored the relationship between the extent to which counselors discussed sexual issues with couples they counsel and their sexual attitudes, training experience

in sexual issues, sexual knowledge, supervision experience addressing sexuality, and clinical experience with sexual issues utilizing correlational and regression analyses. Sexual attitudes were measured by the Brief Sexual Attitudes Scale (BSAS; Hendrick, Hendrick, & Reich, 2006) and consisted of four subscales: Permissiveness (casual sexuality), Birth Control (responsible, tolerant sexuality), Communion (idealistic sexuality), and Instrumentality (biological, utilitarian sexuality). Scores on the BSAS are reverse coded, in that, the lower the score on the subscales the greater that particular sexual attitude. No statistically significant relationships were found between any of the subscales (Permissiveness, r = -.01; Birth Control, r = -.17; Communion, r = -.12; Instrumentality, r = -.04 and the counselors' willingness to initiate sexuality discussions with couples. However, following a stepwise regression analysis to determine predictor variables, a significant regression equation was reported (F = 18.20, p < .01, n = 190), with R^2 = .163) which identified two variables that predicted willingness to initiate sexuality discussions. Sexual attitudes regarding responsibility and tolerance of sexuality (Birth Control) was reported to be a predictor of willingness to address sexual issues with clients and explained 14% of variance. Including the second supervision experience addressing sexuality issues predictor variable, Birth Control sexual attitudes and supervision explained 16% of variance. This finding indicated that certain aspects of an MHCP's attitudes towards sexuality may provide insight into what biases impact frequency of sexuality discussions with clients.

Assessing sexual attitudes is complex, in that, they may differ regarding the topic of sexuality that is discussed, age and gender of the MHCP, or theoretical orientation (Fisher, 2019; Ng, 2007). Particularly, Fisher (2019) explored differences that demographic data may have on attitudes regarding sexuality. Utilizing a survey method, 86 clinical psychologists at the doctoral-level of graduate study completed a questionnaire designed to assess age, gender, sexuality

identity, religious orientation, years in practice, additional sex education, attitudes and beliefs towards sexuality (measured by the BSAS), and presence or absence of sexuality discussions (measured by the SDCS). Pearson product correlations and analyses of variances were conducted to determine relationships and interactions of different variables. Analysis of the gender differences in sexuality discussion and attitudes revealed that there were significant differences between men and women in the frequency that they discussed varying topics that challenged their biases. Overall, significant findings reported that women were more comfortable than men discussing topics including the impact of mental illness on sexual health $F(1, 64) = 3.971$, $p = .051$ and having sex with many partners $F(1, 64) = 14.377$, $p = .002$; Men reported more agreement than women about attitudes regarding sex being the closest form of communication between two people $F(1, 64) = 4.729$, $p = .033$; sexual encounter for two people deeply in love is the ultimate human connection $F(1, 64) = 36.570$, $p = .013$; and, one night stands are sometimes very enjoyable $F(1, 64) = 14.377$, $p = .002$.

Additional findings have disputed the contention that sexual attitudes may influence a MHCP's willingness to engage is sexuality discussions (Bloom et al., 2016). Bloom and colleagues (2016) failed to support previous findings that attitude predicted counselors' propensity to assess client issues specifically related to pornography use. Seven-hundred and sixty-two marriage and family therapists and mental health counselors completed survey items that measured variables including demographics, assessment of clients' pornography use, treatment of clients' pornography use, sexual attitudes (measured by the Sexual Opinion Survey, SOS; Fisher et al., 1988), and attitudes towards erotica (measured by the Attitudes Towards Erotica Questionnaire, ATEQ; Lottes et al., 1993). Sequential logistic regression analyses were used to examine the predictive relationship between therapist assessment and treatment of issues

related to pornography use and attitudes towards pornography and comfort with sexuality. Findings indicated that overall attitudes towards pornography did not predict counselors' assessment of client pornography use c^2 [7, N = 732] = 13.532, p = .060. However, it was found that the second subscale of the ATEQ was found to predict counselors' assessment of client issues related to pornography use (c^2 = 5.948, p = .015). This indicated that counselors with more negative beliefs regarding sexuality were less comfortable assessing clients for their pornography use. Comfort with sexuality and attitudes towards pornography, together, predicted counselors' treatment of client issues c^2 [7, N = 732] = 16.157, p = .024. The model was statistically significant, c^2 [7, N = 732] = 38.011, p < .001, indicating that attitudes towards pornography related to whether counselors did and did not treat clients for issues related to pornography use. In discussing the findings of their study regarding the relationship of attitude and comfort, Bloom and colleagues (2016) purported that MHCP's can hold both negative attitudes about pornography and still be comfortable with sexuality.

Sexual knowledge. Among the research that investigated the influence of sexual attitudes on the extent to which MHCPs discussed sexual issues with clients, many of the students simultaneously focused on the influence of sexual knowledge. This is in part due to some of the instruments that were used to measure sexual attitude and knowledge combined constructs, including the Sexual Knowledge and Attitude Test (SKAT; Miller & Lief, 1979). Early research investigating the relationship between sexual knowledge and the extent to which MHCP's would discuss sexually based topics has yielded significant findings. However, these findings were not supported as more clarity was provided about the nature of sexual knowledge and its relationship to predicting a MHCP's willingness to engaged in discussions of sexual concerns with clients. Sexual knowledge and the influence on a MHCP's willingness to initiate sexuality discussions

with clients has been robustly researched with mixed results (Arnold, 1980; Harris & Hays, 2008; Hays, 2002; Juergens et al., 2009). Several studies have indicated that sexual knowledge was a predictor of willingness, but there may be more refined understanding about sexual knowledge. That is, there is a difference between actual and perceived sexual knowledge in the studies that have investigated this relationship.

Arnold (1980) was the first to investigate the influence that sexual knowledge had on the comfort and willingness of counselors to engage in sexuality discussions with a client. The researcher examined the relationships between completion of a human sexuality course, affective arousal of counselor a sexual human being, sexual knowledge and experience, and willingness and comfort in addressing sexual concerns with clients. Following correlational analyses, there was a significant positive correlation found between the "Knowledge" scale of the SKAT and "Willingness" scale ($r(66) = .31$, $p < .05$), which indicated that the more sexual knowledge a counselor has, the more willingness they demonstrate to discuss sexual issues with clients.

Consistent with Arnold's (1980) findings, Juergens and colleagues (2009) too found that sexuality knowledge associated to the extent to which counselors would discuss sexual issues with clients. The researcher investigated sexual knowledge among graduate rehabilitation counseling students and the influence on their willingness to engage in conversations about sexuality. A path analysis revealed that sexuality knowledge, as measured by the Knowledge subscale of the SKAT (SKAT-Form II; Lief & Reed, 1972), had a direct effect on willingness to discuss sexuality ($b = .33$, $p < .05$). It was recommended that counselor education programs incorporate sexuality training or increase sexuality training into curriculum to increase sexual knowledge.

Hays (2002), published in Harris and Hays (2008), contradicted these findings in that they were unable to find a relationship or interaction between sexual knowledge and direct on counselors' willingness to initiate sexuality discussions with clients. Due to inaccessibility to an instrument that measured sexual knowledge specific to family therapists or mental health professionals, the researchers developed a scale to measure perceived sexual knowledge; participants rated their level of knowledge on eight distinct sexuality dimensions. Following regression analyses to determine a path model, perceived sexual knowledge was not found to have a direct effect on therapist willingness to initiate sexuality discussions. However, there were some inferences made due to the direct effect (.33) that sexuality education and supervision experiences with sexual issues had on perceived sexual knowledge, and the direct effect that perceived sexual knowledge (.64) had on sexual comfort, with sexual comfort being the second strongest predictor of willingness to initiate sexuality discussions with clients. Harris and Hays (2008) purported that sexuality education and supervision experiences expose CITs to factual sexuality knowledge as well as an opportunity to challenges anxieties around sexuality. Further, by exploring these anxieties, CITs increase their sexual comfort; and, as stated previously in the literature, sexual comfort is significantly related to an MHCP's willingness to discuss sexual issues with clients.

Educational experiences. Education and training in sexuality has been consistently cited by researchers as the strongest predictor of a MHCP's willingness to engage in sexual discussions with clients, as the education and training of CITs seems to be the predictor of other variables that contribute to a MHCP's likelihood to initiate discussions of sexuality (Fisher, 2019; Flaget-Greener et al., 2015; Harris & Hays, 2008; Hays, 2002). Ng (2007) explored psychotherapists' biases with clinical experience, knowledge, and expertise in working with

sexuality to better identify sexual issues that are difficult or easy to address therapeutically, subjectivities that facilitate or impede work with sexuality, and the clinical, ethical, professional and personal challenges in sexual psychotherapy. Ten licensed psychotherapists from various mental health disciplines responded to a questionnaire and semi-structed interview. The data were analyzed using Strauss and Corbin's Grounded Theory methodology. A theme emerged regarding the difficulties that the participants disclosed regarding sexual issues clients' present. Inadequate training and/or experience was endorsed as one of themes that contributed to the difficulties of working with clients that present with concerns of sexuality. Particularly, working with sexual orientation, sexual abuse, and erotic transferences were cited as the challenge to having inadequate training and inexperience in working with client sexuality issues. The findings of this study were beneficial, in that, it supported the importance of sexuality education in counselor training utilizing qualitative analysis instead of the quantitative methods used my many of the researchers.

Sexuality education was reported as a significant predictor in the extent of engagement in sexuality discussions with clients in Hays' (2002) investigation. Published in Harris and Hays (2008), Hays (2002) examined the influence of marriage and family therapists' sexuality education, clinical experience with sexuality issues, supervision experience addressing sexuality issues, sexual knowledge, and sexual comfort on the extent to whether they are initiating sexuality related discussions with their clients. A path model analysis showed that marriage and family therapists' sexuality education and supervision experience addressing sexual issues (r = .37) had the largest overall indirect and direct effect on therapists' discussions of sexual issues with clients, suggesting that sexuality education and supervision experience addressing sexuality issues is the best predictor of therapists' initiating sexuality related discussions with clients. It

was suggested by the researchers that, because MHCPs received sexuality education during their schooling, they demonstrated higher sexual knowledge and sexual comfort, and therefore, were more willing to initiate sexual discussions with clients.

Cupit (2010) found a positive correlation ($r = .26$, $p < .01$) between the participants' sexuality discussion with couples and their sexuality education scores. This relationship indicated that as sexuality education increases, sexuality discussion with couples increases. Therefore, sexuality education is related to sexuality discussions with couples. In this relationship, 7% of the variance in the extent to which counselors discussed sexuality with couples is due to counselors' sexuality education. This suggests a low correlation and a small effect size.

Not only does counselor sexuality education and experiences during graduate programs contribute to increased sexuality discussions with clients, but some research has identified the influence of additional sex education beyond graduate school training (Fisher (2019; Miller & Byers, 2009). Fisher (2019) reported a significant relationship between additional sex education after graduate school and discussions of sexuality. In fact, in an investigation of relationships and interactions between psychologist factors and psychologists' comfort and willingness to engage in sexuality discussions, additional sex education was the only variable determined to have a significant effect on overall comfort and willingness.

Miller and Byers (2009) supported this finding in their study assessing the relationship of psychologists' continued education related to sexuality and the extent to providing interventions to clients with sexual issues. On hundred and five clinical and counseling psychologists completed an internet survey that measured for the variables: continued sex education and training, type of feedback received regarding ability to address sexuality issues, willingness to

treat sexual issues, and sexual knowledge. Correlations were used to examine the relationships between the variables and willingness to treat clients' sexual concerns. Findings indicated a significant positive relationship between additional sex education post-internship and willingness to treat clients' sexual concerns ($r = .390$, $p < .001$). It could be implied that additional sex education may be pertinent to help MHCP's feeling more competent in addressing a range of sexual issues that clients present.

Supervision experience. A MHCP's supervision experiences with topics of sexuality have also been discussed in the literature as one of the stronger predictors of willingness to engage is sexuality discussions with clients. Harris and Hays' (2008) path analysis found that of the total direct and indirect effects of each variable measured, sexuality education and supervision experiences ($r = .37$) had the greatest influence on therapists' initiating sexuality discussions with their clients. MHCPs consistently reported that it was their supervision experiences with sexual issues that contributed to the initiation of conversations about sexual concerns with clients.

Cupit (2010) expanded their research and examined MHCPs and the relationship of sexual attitudes, training experience in sexual issues, sexual knowledge, supervision experiences addressing sexuality, clinical experience with sexual issues, and willingness to discuss sexual issues with couples. Cupit (2010) confirmed the finding that supervision experiences significantly predicted the ability to address sexuality concerns with couples. Correlation and regression analyses were utilized to evaluate the relationship and interaction between independent variables and the dependent variable. A significant positive correlation ($r(228) = .38$, $p < .01$) was found between participants experience in supervision with sexuality issues and their sexuality discussions with clients. Further, a significant regression equation ($F = 18.20$, $p <$

.01, n = 190), with R^2 = .163 revealed that supervision experiences addressing sexuality issues was the second strongest predictor to participants' willingness to initiate sexuality discussions with couples. Together with Birth Control attitudes, explained 16% of variance.

Supporting these earlier findings was Moore (2018), who examined the relationships between independent variables: therapists' attitudes, knowledge, and personal characteristics and dependent variables: therapists' comfort with sexual topics and willingness to discuss sexual topics. Ninety licensed marriage and family therapists (LMFT) were surveyed to provide quantitative measures for the variables. Correlational analyses revealed significant positive relationships between therapists' graduate sexuality training (r = .31, p < .001), supervision experience (r = .32, p < .001), and clinical experience (r = .32, p < .001) and willingness to discuss sexual topics with clients. Graduate sexuality training explained 9.61% of the variance in a therapists' willingness to discuss sexual topics; supervision experience explained 10.24% of the variance; clinical experienced explained 10.24% of the variance. Coefficients failed to demonstrate any significant relationships with four subscales of sexual attitudes and willingness to discuss sexual topics with clients. Further, a significant relationship was found between a therapist's practice setting and therapist's willingness to discuss sexual topics with clients (r = .22, p = .036), indicating that therapists who are more willing to discuss sexual topics are more likely to be in private practice than other settings. A stepwise multiple linear regression was utilized to investigate whether the independent variables predict a therapist's willingness to discuss sexual topics with clients. Moore (2018) reported that clinical experience and supervision experience were the two variables that predicted therapist's willingness to discuss sexual topics with clients, explaining 18% of the variance in the dependent variable.

Demographic factors. Many demographic factors have been examined analyzing their relationship with and influence on the extent to which MHCPs discuss sexual issues with clients. Cupit (2010) investigated the relationship of several demographic variables (sex, age, strength of faith, sexual orientation, number of years practicing, practice setting, type of license, type of graduate program, and relationship status) with the willingness of counselors to initiate sexuality discussions with couples. Pearson product moment correlations and a chi square measure of association were calculated to examine the relationships between the demographic variables and the extent to which counselors discuss sexual issues with couples. Two statistically significant relationships with counselor willingness to initiate sexuality discussions with couples among the variables. A significant relationship was found between differences in graduate specializations (addiction, career, clinical mental health/community, marriage, couple, and family, school, student affairs and college) studied in graduate work was found to associate with willingness (X^2 = 318.7, df = 250, n = 202, $p > 0.01$). This indicates that depending on the graduate specialization, such as clinical mental health/community counseling or marriage and family counseling, may be more or less willing to discuss sexual issues with couples. Cupit's (2010) study reported that the extent to which counselors discussed sexual issues with couples did not relate to their sex, practice setting, licensure type, relationship status, sexual orientation, strength of faith, and number of years practicing. Other studies investigating these variables found both support and contradictory findings, in that, sex, age, and theoretical orientation have been shown to influence sexuality discussions with clients.

Gender. Some research has indicated that gender may contribute to a MHCP's comfort and willingness to discuss sexual based health issues with clients (Bloom et al, 2016; LoFrisco, 2013). One study found gender, particularly comparisons between males and females, to be the

strongest predictor of a MHCP's propensity to assess and treat client issues related to pornography use (Bloom et al., 2016). Bloom and colleagues (2016) examined factors that may influence a marriage and family therapists or mental health counselors' propensity to assess for or treat client pornography use. Sequential logistic regression analyses were used to examine the predictive relationship between therapist assessment and treatment of issues related to pornography use and attitudes towards pornography and comfort with sexuality. The models included demographic variables, which alone, were statistically significant predictors of counselors' assessment of client's issues related to pornography use c^2 [3, N = 739] = 13.491, p = .004 and treatment of client's issues related to pornography use c^2 [3, N = 739] = 21.854, p < .001. Gender was the strongest predictor of counselors' assessment of pornography use (c^2 = 3.903, p = .048) and treatment of client issues related to pornography use (c^2 = 9.928, p = .002). These results indicated that men were more likely than women to both assess and treat clients for issues related to pornography.

LoFrisco (2013) supported these findings that gender may be an influential factor in the extent to which a counselor discusses sexual issues with couples in their clinical practice. LoFrisco (2013) reported a significant relationship between the gender of the counselor and the frequency of initiation in discussions of sexual concerns with couples, X^2 (3, N = 61) = 12.32, p < .01), but no relationship was found with individual client cases, X^2 (2, N = 63) = 3.96, p < .05), Cramer's V was calculated at .44 for couples cases. LoFrisco (2013) indicated that female counselors reportedly raised the topic of sexuality more frequently than male counselors. The researcher discussed that this finding may suggest that females conceptualize their own sexuality as contextual and are likely to conceptualize the couples they serve based on relationship factors that affect sexuality.

Age. Another demographic that has been evaluated in the literature is age of the MHCP. Investigations, evaluating age as a contribute to willingness to discuss sexual concerns with clients has been confirmed. Fisher's (2019) examination of psychologists' factors that influence sexuality discussions with clients revealed significant findings. Overall age was not found to have a significant relationship with overall comfort and willingness to engage in sexuality discussion. However, several significant positive relationships between age and specific topics of sexuality were found and those include sexual dysfunction $r(65) = .376$, $p = .002$; client satisfaction with their sexual life $r(65) = .415$, $p = .001$; and sexual interaction pattern $r(65) = .333$, $p = .006$. These findings indicate that older psychologists addressed a greater range of sexuality topics.

Cupit (2010) found that graduate specialization and age most significantly influenced counselors' willingness to discuss sexual concerns with clients. The researcher reported that age had a significant positive relationship with willingness ($r = .18$, $p < .01$), indicating that the older the counselor age the more willing the counselor is to initiate sexuality discussions with couples.

Theoretical orientation. Fisher's (2019) examination of influential therapist factors in relation to engagement is sexuality discussions reported significant findings in the effects of therapists' theoretical orientation. Theoretical orientations comprised psychodynamic, cognitive-behavioral, and eclectic models. A one-way ANOVA found a significant difference ($p = .034$) for those participants that identified as psychodynamic ($M = 5.53$, $SD = 1.55$) than those subscribed to cognitive behavioral orientation ($M = 3.83$, $SD = 1.03$) regarding addressing client sexual satisfaction $F(2, 25) = 3.46$, $p = .039$. Further, an ANOVA revealed another significant difference ($p = .05$) for client sexual interaction pattern between means of those identifying as psychodynamic ($M = 5.24$, $SD = 1.79$) and those identifying as cognitive-behavioral therapists

(*M* = 3.67, *SD* = 1.44); and, between psychodynamic orientation and eclectic (*M* = 3.83, *SD* = 1.89); *F*(2, 52) = 4.18, *p* = .021. Regarding the topic sexual relationship enhancement, an ANOVA revealed a significant difference (*p* = .005) between psychodynamic orientation (*M* = 5.06, *SD* = 1.78) and cognitive behavioral orientation (*M* = 2.92, *SD* = 1.08); and, between psychodynamic orientation and eclectic (*M* = 3.18, *SD* = 1.89); *F*(2,52) = 7.713, *p* = .001. Another significant effect was obtained for theoretical orientation and how sexuality was discussed in family of origin *F*(2,52) = 3.321, *p* = .044. There was a significant difference (p = .078) between psychodynamic orientation (*M* = 5.29, *SD* = 1.40) and cognitive-behavioral orientation (*M* = 4.08, *SD* = .79); and, between psychodynamic orientation and eclectic approach (*M* = 4.26, *SD* = 1.71). These findings indicated that the majority of significant differences lies between psychodynamic orientation and cognitive behavioral orientation, indicating that those psychologists who subscribed to the psychodynamic approach to therapeutic intervention embraced more comfort and willingness in addressing specific sexuality related questions.

Sexual Intervention Self-Efficacy and Willingness to Initiate Sexuality Conversations

The theory of self-efficacy posits that there is a relationship between fear arousal and perceived self-efficacy, and further that individuals who experience higher levels of fear arousal will engage in avoidance behaviors (Harris & Hays, 2008). This concept was demonstrated through Miller and Byers' (2008, 2012) pioneered construction and investigation of sexual intervention self-efficacy, in relation to whether MHCPs would discuss sexual concerns with clients.

Miller and Byers (2008) first introduced the Sexual Intervention Self-Efficacy Scale (SISES; Miller & Byers, 2008) in their investigation of the self-efficacy of 172 students enrolled in a clinical psychology graduate program in Canada and the United States in addressing sexual

concerns and problems. Among sexual intervention self-efficacy and willingness to treat sexual issues, the researchers examined relationships between demographic factors (age, gender, years of graduate training, number of practicum hours completed), sexual intervention education and training experiences, sexual anxiety, and sexual conservatism (attitudes). The purpose of this study was to examine predictors of sex therapy experience gained during graduate school as well as of sexual intervention self-efficacy. The findings did not provide empirical evidence for the relationship between sexual intervention self-efficacy and willingness to initiate sexuality discussions with clients. However, Miller and Byers (2012) extended the investigation of sexual intervention self-efficacy in the only investigation of the relationship between sexual intervention self-efficacy and willingness of MHCP's to discuss sexual issues with clients. One-hundred and ten psychologists who were members of the Canadian Registrar of Health Service Providers and the American Psychological Association were participants in this study. Variables investigated included demographic characteristics, training, and employment, sexual intervention education and training experiences, post-internship sexual intervention education and training experiences, type of feedback received regarding ability to address sexuality issues, sexual conservatism (attitudes), and feelings about sexual behaviors. Path analyses revealed direct effects of sexual intervention self-efficacy on willingness to treat ($b = .79$, $p < .001$). Based on R^2 values, graduate sex education, post internship sex education, and the skills and information self-efficacy subscales of the SISEQ explained 62% of the variance in willingness of psychologists to treat sexual issues. These findings suggested that psychologists' failure to address sexuality issues with their clients was due to a lack of self-efficacy regarding their assessment and treatment of clients' sexual concerns and problems. To date, no other research has examined the

relationship between sexual intervention self-efficacy and willingness to initiate sexuality discussions with clients.

Anxiety and Willingness to Initiate Sexuality Discussions

Anxiety has been shown to influence comfort and willingness to treat sexual concerns of clients (Fischer et al., 1988). Harris and Hays (2008) did not find a direct effect between sexual knowledge and increased willingness to discuss sexual concerns with clients, which they suggested was a result of the moderating effect of counselor anxiety. The researchers reported that besides being knowledgeable, therapists must be able to "sit with the anxiety" (p. 248) in order to increase comfort with making the decision to initiate sexual discussions with clients. Fear arousal, especially anticipatory fear, has been demonstrated to influence avoidance behavior (Bandura, 1977). There is no known research that has investigated the independent variables of state or trait anxiety and the dependent variable of willingness to treat sexual concerns. Despite the research demonstrating the significance of anxiety in influencing a MHCPs general performance, to date there have not been any investigations that have examined such a variable as it relates to the extent at which MHCPs are approaching, rather than avoiding, crucial conversations with clients about their sexuality needs.

Conclusion

The willingness of MHCPs to initiate inquiries and discussions about sexuality issues with clients continue to be detrimental to the mental health counseling field, as sexuality is an integral and prevalent concern for clients. Identifying variables that contribute to or predict the extent to which a MHCP initiates these discussions will contribute to counselor education curricula, thereby equipping MHCPs to be more effective in their practice. The research in this

area has been scant and has primarily focused on the identification of relationships among a range of variables.

Much of the existing literature has identified external factors, such as educational, observational, and supervisory training experiences, which lends to the research that examines self-efficacy. No study, to date, has examined personality variables, such as anxiety, as it influences willingness to initiate sexuality discussions with clients. Sexual intervention self-efficacy literature, specific to a MHCP's confidence regarding topics of sexuality, is limited, despite the significance that self-efficacy theory posits about learning.

This study contributes to the research by investigating the relationships between sexual intervention self-efficacy, state anxiety, trait anxiety, and the willingness to initiate sexuality discussions with clients. The findings of this study revealed information that can facilitate personal awareness among MHCPs, particularly in counselor education programs among CITs, and contributes to enhancing MHCP competence and skill.

CHAPTER 3

METHODOLOGY

Chapter one provided an introduction to the purpose of this study, while including research questions and hypotheses. Chapter two reviewed the literature to support the significance of this study, providing a rationale for the need to examine the relationship between sexual intervention self-efficacy, state anxiety, trait anxiety, and the willingness to discuss sexuality issues. This chapter will restate the purpose of the study and outline the methodology used in this study. Specifically, this chapter will explain the study rationale, target population, procedures, instrumentation, and research design. The participants section will describe the intended sample surveyed for this study, including potential characteristics, clarifying inclusion requirements, and desired number of participants. The procedures section will detail the research procedures, explaining how the data will be collected. The instrumentation section will review the measurements used in the study including a demographic questionnaire, the Sexual Intervention Self-Efficacy Questionnaire (SISEQ; Miller & Byers, 2008), the State Trait Anxiety Inventory (STAI; Spielberger, 1983), and the Sexuality Discussions with Clients Scale (SDCS; Harris & Hays, 2008). The final section provides the research questions and methodological procedures utilized in this investigation.

Purpose of the Study

The purpose of this study was to investigate factors that influence MHCP's willingness to engage in and discuss sexuality with clients for whom they provide counseling. Specifically, the study focused on the following independent variables: sexual intervention self-efficacy, state anxiety, trait anxiety, and the dependent variable: willingness to discuss sexuality concerns with clients. Sexual intervention self-efficacy has been linked to therapist willingness to address

sexual concerns in counseling (Harris & Hays, 2008; Miller & Byers, 2008, 2012). The experience of anxiety has been shown to be related to a MHCP's skill attainment and performance (Bandura, 1997; Koth, 2019), yet it has not been explicitly examined in relationship to sexuality discussions in counseling. There has been some research pertaining to the relationship among the independent variables (Miller & Byers, 2008). However, the construct of anxiety has been measured differently, assessing sex anxiety interchangeably with sexual comfort, and not specifically general anxiety (Arnold, 1980; Harris & Hays, 2008; Miller & Byers, 2008). The literature indicated a need to investigate the potential relationship between general anxiety, sexual intervention self-efficacy, and a MHCPs willingness to engage in sexuality discussions with clients (Arnold, 1980; Harris & Hays, 2008; Miller & Byers, 2008). Given that MHCPs have to provide treatment services that fosters the right of clients to control their lives, does not harm, promotes health and wellbeing, treats individuals equitably, honors the commitments within the client-professional relationship, and delivers truthfulness, it is imperative to examine the variables that may influence these professional behaviors as they relate to all aspects of human functioning, including sexuality (ACA, 2014).

Research Methodology and Rationale

The purpose of this study guided the research methodology and associated design that was employed in this investigation. This study examined specific variables that were thought to influence a particular outcome, and after assumptions were met, to identify predictors of a MHCP's willingness to engage in sexuality discussions, utilizing regression analyses. A quantitative research design was employed to examine numerical relationships between the variables (Creswell, 2014). The nature of this study was exploratory, as the independent variables that were investigated had not been extensively empirically examined in the research.

Thus, it is hoped that this study will significantly contribute to the literature. The researcher used a survey design to explore the predictive relationships among the variables (Creswell, 2013). The survey method is appropriate for analyzing data from standardized instruments with large numbers of participants (Creswell, 2013). This study was guided by the following research questions:

1. Is there a relationship between sexual intervention self-efficacy (as measured by SISEQ), state anxiety (as measured by STAI), and trait anxiety (as measured by STAI) among mental health counseling professionals (MHCPs)?
2. To what extent do sexual intervention self-efficacy (as measured by SISEQ), state anxiety (as measured by STAI-S), and trait anxiety (as measured by STAI-T) predict willingness to discuss sexual issues with clients (as measured by SDCS) among mental health counseling professionals (MHCPs)?

Participants

The participants in this study included licensed mental health counseling practitioners (MHCPs). These individuals hold licenses in either professional clinical counseling (LPCC) or marriage and family therapy (LMFT) in the state of Minnesota and are actively engaged in providing counseling to clients. There are approximately 2500 LPCCs (MBBHT, 2018) and 2800 LMFTs (MNMFT, 2020) in the state of Minnesota. Having a focus on participants who hold a license decreased the likelihood of extraneous demographic variables, honing in on a particular sample set. The intention of choosing the state of Minnesota and utilizing licensing boards rather than association memberships was to narrow the inclusion criteria process, as those MHCPs who participate in national associations for professionals may not necessarily be licensed. As such, this particular study is inclusive of those licensed to practice independently in the state of

Minnesota. Mailing lists were purchased from the Minnesota Board of Behavioral Health and Therapy (MN-BBHT) and the Minnesota Board of Marriage and Family Therapy (MN-BMFT). Participants were recruited via US mail.

Sample size. To determine sample size (N), a statistical power analysis was performed utilizing three factors. The first was to determine the power of statistical analysis. The power was determined based on a convention proposed for general use, and the ability of a test to find effect assuming that one exists (Field, 2013). The power is expressed as $1 - ß$ (Field, 2013). Cohen (1988, 1992) recommended a conservative .2 probability that the test will fail to detect an effect. For this reason, 1 - .2 would be .8. The power for this study was set to .8, meaning that it has an 80% chance of detecting an effect given that it exists. The second factor involved a determination of the effect size, which was used to measure the relationships between the variables and magnitude of those results. Based on similar research conducted by Sousa (2018) comparing two predictor variables with comfort with sexuality, the effect size for this study was considered to be medium and recommended by Cohen's (1988) criteria. Based upon the literature and regression analyses, a moderate effect size of .15 was used for this study (Cohen, 1988). The third factor included consideration of the level of significance that will impact the sample size. To reduce the chance of a Type II error, which occurs when a conclusion is made that a significant relationship exists when in reality, there is not a relationship between variables, an alpha was set to .10 (Heppner et al., 2016). This is not common for social sciences research. However, as this is the first study to investigate the relationship between state-trait anxiety and the willingness to discuss sexuality with clients, and only the second study to examine the relationship between sexual intervention self-efficacy and the willingness to discuss sexuality with clients, it is common to propose a confidence level suggesting there is a 10% chance the

null hypothesis will be rejected even if there is no real difference (Field, 2013). This study will use a Pearson's product moment correlational matrix for Research Question 1 and a multiple regression for Research Question 2. A G*Power (Erdfelder et al., 1996) a-priori power analysis using an *F* test for multiple linear regression with a fixed model and R^2 deviation from zero to compute for N (sample size) was conducted to determine sample size given the three factors. This study has three predictor variables, and given the parameters set for this study, the G*Power indicated a minimum sample size of 62 participants.

Procedure

After receiving IRB approval, the investigator distributed an introductory letter via the US mail service (Appendix A), which outlined the content, purpose, and confidentiality of the current study, and the possible implications of participating in the study. The introductory letter recruited participants to complete a Qualtrics (http://www.qualtrics.com) survey that was accessible via a secure link provided in the correspondence. The Qualtrics link included, in this order, a consent form (Appendix B), a demographic questionnaire (Appendix C), the Sexuality Discussion with Clients Questionnaire (Appendix D), the Sexual Intervention Self-Efficacy Scale (Appendix E), and the State-Trait Anxiety Inventory (Appendix F). The participants were informed that the survey, should they consent, would likely take approximately 10 to 20 minutes to complete.

With the average response rate of 33%, and the goal for a sample size of 70, to make room for incomplete responses, it was suggested to invite 300 participants. A random selection of 150 LPCCs and 150 LMFTs were mailed introductory letters inviting them to participate in the study. After a week and a half of the survey being available online, and only 18 completed survey responses, an additional 100 introductory letters were sent to another randomly selected

50 LPCCs and 50 LMFTs. Following another two weeks, and minimal responses, an additional 510 introductory letters were sent to 255 of each group of randomly selected LPCCs and LMFTs. Of the 910 letters mailed to recruit participants, approximately 20 were returned to the sender as undeliverable, and 67 surveys were submitted by the participants, indicating a very low response rate of 7.52%.

Protection of Participants and Informed Consent

The consent form was intended to explain participants rights, potential risks, and ethical concerns, allowing the individual to be informed prior to participating in the study. The explicit sexual material could potentially trigger discomfort, shame, and stress, which falls under the area of participant welfare and was detailed in the consent form (Appendix B). The consent form informed participants that their participation is voluntary, provided them with the affirmation that they can quit at any time should they feel uncomfortable or otherwise compromised during the study before they gained access to the survey through Qualtrics. The results were tracked on Qualtrics, verifying the data had no corruption or errors in the transmission. The data was then analyzed using the Statistical Package for the Social Sciences (SPSS) 27 (IBM Corp., 2020).

Instruments

A demographic survey and three standardized assessments were used in this study. The three inventories included the Sexual Intervention Self-Efficacy Scale (SISES; Miller & Byers, 2008), State-Trait Anxiety Inventory (STAI; Spielberger, 1983), and Sexual Discussions with Clients Scale (SDCS; Harris & Hays, 2008).

Demographic Questionnaire

The researcher created a demographics questionnaire that was administered to participants. The questionnaire was intended to collect demographic characteristics about each of

the participants. The demographic questionnaire solicited information about participant's (a) gender, (b) age, (c) race/ethnicity, (d) belief affiliation, (e) sexuality, (f) licensure type, (g) practice setting, (h) years in professional practice, (i) educational levels, and (g) human sexuality education and training experiences.

Sexual Discussions with Clients Scale

Harris and Hays (2008) developed the *Sexuality Discussions with Clients Scale* (SDCS) to measure sexuality-related discussions therapists have with their clients. This 9-item scale is intended to measure the presence or absence of sexual discussions with clients. Each item is a self-report Likert measure that assess the extent to which therapists have sexual discussions with their clients. The scores of the Likert response format range from 1 (strongly disagree) to 7 (strongly agree) or 1 (never) to 7 (very often). The higher the scores endorsed indicates that the therapist is more willing to initiate sexuality discussions with their clients. This scale has demonstrated good internal consistency with a Cronbach's alpha of .90 (Harris & Hays, 2008) and .82 (Houghton, 2018). The use of this scale has been limited (Cupit, 2010; Fisher, 2019; Harris & Hays, 2008; Houghton, 2018). Permission was obtained, via email, from the measure developer for use in this research.

Sexual Intervention Self-Efficacy Questionnaire

The *Sexual Intervention Self-Efficacy Questionnaire* (SISEQ) was developed by Miller and Byers (2008) as an instrument in an exploratory study that examined variables that might be related to their newly conceptualized sexual intervention self-efficacy construct. This instrument assesses beliefs that an individual may hold regarding their ability to address sexuality-related topics with clients (Appendix D). The first version of the SISEQ included 43 items, which were based off counseling self-efficacy and sex therapy literature. Through factor analytic procedures

the scale was reduced to 23 items that were represented by identified factors. Further examination found that four of the 23 items demonstrated an inability to effectively measure the construct and were then removed from the scale, ultimately leaving 19 items in the final version of the SISEQ. There are three subscales; (1) the 5-item *Sexual Comfort/Bias* subscale (Comfort/Bias Self-Efficacy) that measures self-efficacy beliefs about an individual's perceived ability to appear comfortable during discussions of sexual issues while preventing from bias interfering with treatment (e.g., *There are issues related to sexuality that I would not feel comfortable talking to a client about*); (2) the 7-item *Relaying Sexual Information* subscale (Information Self-Efficacy) that measures self-efficacy beliefs an individual holds about their ability to relay accurate sexual-based information (e.g., *I am confident that I can relay accurate information to clients about sexual orientation/identity issues*); and (3) the 7-item *Sex Therapy Skills* subscale (Skills Self-Efficacy) that measures self-efficacy beliefs an individual holds regarding their knowledge and ability to utilize sex therapy techniques, and treat specific sexual problems (e.g., *I have very little knowledge of the interventions used to treat sexual problems*). All the items of each subscale require a rating on a 6-point Likert-type scale that ranges from 1 (*strongly agree*) to 6 (*strongly disagree*). Scores on the Sexual Comfort/Bias subscale will then range from 5 to 30, with higher scores indicating higher levels of self-efficacy. Scores for both the Sex Therapy Skills and Relaying Sexual Information subscales will range from 7 to 42, again, with the higher scores indicating higher levels of either skills self-efficacy or information self-efficacy. Miller and Byers (2008) reported high internal consistency with Sex Therapy Skills $\alpha = .87$, Relaying Sexual Information $\alpha = .88$, Sexual Comfort/Bias $\alpha = .73$, and Total Sexual Intervention Self-Efficacy Scale $\alpha = .88$. Miller and Byers (2012) and Hayes (2019) demonstrated acceptable internal consistencies on the SISEQ: Sex Therapy Skills $\alpha = .88$,

Relaying Sexual Information α = .82, Sexual Comfort/Bias α = .64, and Total Sexual Intervention Self-Efficacy Scale α = .92. Since the initial development, this instrument has been used several times (Hayes, 2019; Miller & Byers, 2008, 2012). Permission was obtained, via email, from the measure developer for use in this study.

State-Trait Anxiety Inventory

The *State-Trait Anxiety Inventory* (STAI; Spielberger, 1983) (Appendix F) has been well evaluated, and major revisions have been implemented to construct and develop an empirically sound instrument of anxiety. It is comprised of two separate self-report forms, each 20-items. The STAI includes a scale for state anxiety (S-Anxiety scale; Form Y-1) that measures the presence and severity of current anxiety symptoms, and a scale for trait anxiety (T-Anxiety scale; Form Y-2) that measures generalized propensity to be anxious. Each item on the inventory has a four-point Likert-type scale that are anchored from 1 (*not at all*) to 4 (*very much so*). The scores for each of the scales range from 20 to 80. Higher scores on each of the scales indicate higher state anxiety or higher trait anxiety. The S-Anxiety scale assesses feelings of apprehension, tension, nervousness, and worry, and scores of the measure will increase as response to perceived danger and psychological stress increase. The T-Anxiety scale has been shown to adequately assess anxiety-proneness, which will differ between individuals with tendencies to perceive stressful situations as dangerous or threatening, responding to such situations with elevations in the intensity of S-Anxiety. Those individuals who have exhibited high T-Anxiety have been shown to more frequently exhibit elevations in S-Anxiety than those individuals with low T-Anxiety. Those same individuals with higher T-Anxiety will more likely have a tendency to respond to situations that involve interpersonal relationships and/or threaten self-esteem (S-Anxiety) to a greater intensity.

Spielberger (1983-2020) outlined the construction and validation process of the STAI. Initial evaluation consisted of gathering three widely used anxiety scales and administering them to 288 psychology students. Those items that demonstrated a correlation of .25 or higher were rewritten so that the anxiety content was retained. There were 177 items that remained, essential psychological content was retained, but each item was rewritten and delineated to demonstrate state or trait anxiety measures. Further screening for ambiguity, redundancies, and vagueness was conducted and left 124 items for more evaluation. These remaining items were administered to a sample of 54 undergraduate students. The participants were asked to endorse each item for how well it described them in general and at that moment. Items that demonstrated a correlation of .35 or higher and those that did not have more than 20% of the subjects reporting "doesn't apply" were retained. The remaining 66 items following this third screening were administered to a fourth sample of college students (n=265). When presented with the measures, the participants were first asked to imagine themselves in various situations that would either provoke anxiety or would be relaxing (T-Anxiety set). They were then asked to imagine actually being in those situations and response to how they would feel in that situation (S-Anxiety set). Analyses to determine the extent to which each item discriminated between the two situations was conducted and 44 items were retained. Point-biserial and between-item correlation analyses were conducted following administration to a sample of 561 male and 249 female freshmen at a research university. These analyses left 32 items that had acceptable psychometric properties to measure both T-Anxiety and S-Anxiety. The final evaluation of the remaining items included item-selection and validation processes. This particular evaluation was intended to focus on the validity of individual items as measures of S-Anxiety. Four hundred undergraduates were provided the 32-item S-Anxiety scale. They were then administered the scale again two months

later. Twenty items were found to best meet criteria for measuring S-Anxiety, which item-validation procedures were already conducted for measuring T-anxiety, resulting in the development of Form A of the STAI. The two subscales of Form A, S-Anxiety and T-Anxiety were analyzed and found to have moderately high correlations. Alternatively, Form-B was constructed using replacement items that had previously been found to discriminate between S-Anxiety and T-Anxiety and consisted of 20 items. Following several reviews and modifications of each of the items for each scale, Form B was revised. The revised Form B and other measures of anxiety were given to a sample of over 300 undergraduates. S-Anxiety and T-Anxiety scales showed a high correlation with other standard measures of state and trait anxiety. The revised Form B was administered to a second sample of 486 male and 575 female psychology students. This study provided normative data for the first *STAI Preliminary Test Manual* (Spielberger et al., 1967). Item-replacement processes occurred, and the result was Form X which was published in the *STAI Manual* in 1970 (Spielberger et al., 1970). Spielberger and colleagues (1980) revised Form X to construct and validate Form Y, the present form of the scale. Factor analyses and content analysis were conducted on the individual items of Form Y. Factor structure was first analyzed following administration to 202 male and 22 female tenth-grade high school students, and then to 1,728 male U.S. Air Force recruits. In both samples, cofactor correlations were greater than .90, providing evidence for state-trait distinction in the measurement of anxiety. Evidence for concurrent, convergent, and divergent validity was demonstrated by researching contrasted groups, correlations of the T-Anxiety scale with other measures of trait anxiety, correlations of the STAI scales with other widely used measures of personality and adjustment, correlations of the STAI scales with measures of academic aptitude and achievement, and investigations of the effects of different amounts of types of stress on S-Anxiety scores.

Reliability for Form Y was demonstrated through assessing for stability coefficients based on two groups of high school students that were re-administered the scale after 30 days and then again after another 30 days. The test-retest correlations for T-Anxiety scale were lower, ranging from .65 to .75. The stability coefficients for the S-Anxiety scale were also relatively low, ranging from .16 to .62. This was expected due to the validity of the measure to reflect influence of situational factors. However, due to this discrepancy, internal consistency measures were computed utilizing Formula KR-20 (modified by Cronbach, 1951). Alphas for Form Y S-Anxiety scale were shown to range from .86 to .95, with a median coefficient of .93. Alpha reliability coefficients for the T-Anxiety scale ranged from .89 to .96, with a median coefficient of .90. Stability is relatively high for STAI T-Anxiety and low for the S-Anxiety scale. Internal consistency for both T-Anxiety and S-Anxiety scale was high.

The STAI in its entirety, both S-Anxiety (Form Y-1) and T-Anxiety (Form Y-2), will be used for this study. This measure was intentionally placed in the survey following the SISE and SDCS in order to allow for provocative statements from the former measures to potentially evoke a stressful response, demonstrating a more realistic measure of S-Anxiety.

Data Screening and Descriptive Statistics

The data analysis software employed for this research was SPSS 27.0 (IBM Corp., 2020). Prior to analyzing the research questions, a frequency analysis was run to ensure that the data was entered correctly and participants with missing answers were omitted. Descriptive statistics were provided for the 10 demographic questions asked pertaining to (a) gender identity, (b) age, (c) racial/ethnicity identity, (d) belief affiliation, (e) sexual identity, (f) licensure type, (g) practice setting, (h) years in professional practice, (i) educational levels, and (g) human sexuality

education and training experiences. All 10 demographic questions were coded as nominal categorical variables.

Research Question One

Is there a relationship between sexual intervention self-efficacy (as measured by SISEQ), state anxiety (as measured by STAI), and trait anxiety (as measured by STAI) among mental health counseling professionals (MHCPs)?

$H1_0$: There are no significant relationships between sexual intervention self-efficacy (SISEQ total score), state anxiety (STAI-S total score), and trait anxiety (STAI-T total score) among mental health counseling professionals (MHCPs).

$H1_a$: There are significant relationships between sexual intervention self-efficacy (SISEQ total score), state anxiety (STAI-S total score), and trait anxiety (STAI-T total score) among mental health counseling professionals (MHCPs).

Statistical analysis. RQ1 was analyzed using a descriptive correlation design. A Pearson's product-moment correlation statistic was used to determine the strength and direction of a linear relationship between two continuous variables (Laerd Statistics, 2018). The test generates a coefficient (*r*) and the value of the coefficient ranges from -1, to show a perfect negative relationship, to +1, that demonstrates a perfect positive relationship, with 0 (zero) indicating no relationship (Laerd Statistics, 2018). A coefficient that is between 0.5 and 1.0 would indicate a strong correlation, a coefficient between 0.3 and 0.5 would indicate a moderate correlation, while a coefficient that is between 0.1 and 0.3 would indicate a small correlation. This research question examined the correlation between three independent variables: one sexual intervention self-efficacy variable, one state anxiety variable, and one trait anxiety variable, to determine if there was a relationship between paired variables. The variables were transferred

from Qualtrics to an Excel file. The Excel file of data was imported into SPSS for analysis. The scores from each of the variables were analyzed using a Pearson's R Correlation Matrix. In order to utilize a Pearson's correlation statistical analysis, the data must have met five assumptions. The first two assumptions state there needs to be two continuous variables, and that the two continuous variables are paired, respectively (Laerd Statistics, 2018). The third assumption asserts that there should be a linear relationship between each of the pairs. The fourth assumption, stating that there should be no significant outliers, which are data points on the scatterplot that do not follow the linear relationship as demonstrated in the scatterplot and can affect the coefficient value. The fifth assumption asserts the necessity to have both variables in the correlation to be normally distributed; bivariate normality. This allows for assessing statistical significance. Assumptions were met and statistical significance was demonstrated in order to determine whether the null hypothesis could be accepted or rejected. This was done by determining a two-tailed significance value of .10. Examination of the assumptions and statistical analyses is outlined in Chapter 4.

Research Question Two

To what extent do sexual intervention self-efficacy (as measured by SISEQ), state anxiety (as measured by STAI-S), and trait anxiety (as measured by STAI-T) predict willingness to discuss sexual issues with clients (as measured by SDCS) among mental health counseling professionals (MHCPs)?

$H2_0$: Sexual intervention self-efficacy (SISEQ total score), state anxiety (STAI-S total score), and trait anxiety (STAI-T total score) will not significantly predict willingness to discuss sexual issues with clients (SDCS total score) for mental health counseling professionals (MHCPs).

$H2_a$: Sexual intervention self-efficacy (SISEQ total score), state anxiety (STAI-S total score), and trait anxiety (STAI-T total score) will significantly predict willingness to discuss sexual issues with clients (SDCS total score) for mental health counseling professionals (MHCPs).

Statistical analysis. RQ2 was analyzed using a multiple regression in order to predict a dependent variable based on multiple independent variables (Laerd Statistics, 2018). Further, a multiple regression can determine the relative contribution of each of the independent variables to the total variance explained. All eight assumptions were met and the extent to which three independent variables: sexual intervention self-efficacy variable, state anxiety variable, and trait anxiety variable contributed to the total variance of predicting the dependent variable: willingness to initiate sexuality discussions with clients variable was examined. The first and second assumptions have been met because all variables are measured on a continuum of numerical values. The next six assumptions relate to the nature of the data. The third assumption of independence of observations will be met by testing for 1st-order autocorrelation by using the Durbin-Watson statistic. This will have been run as a part of the multiple regression procedure. The fourth assumption will require a test of linearity. This will be assessed by producing a scatterplot of studentized residuals against predicted values. Further, a linear relationship will be observed by reviewing partial regression plots between each independent and the dependent variable. The fifth assumption asserts the need for the data to show homoscedasticity of residuals. The same plot used to prove the fourth assumption of linearity is used for this interpretation. The sixth assumption will be met by the data not showing multicollinearity. In order to understand which independent variable contributes to the variance of the dependent variable, two or more independent variables cannot be highly correlated. The seventh assumption

will be met as long as there are no significant outliers, leverage points, or influential points. Outliers will be detected by using case wise diagnostics and studentized deleted residuals in SPSS. High leverage points will be checked for by using SPSS. Influential points will be checked for by using a measure referred to as Cook's Distance. The errors/residuals must be checked for normal distribution in the final eighth assumption. The methods used to check for errors/residuals is by generating a histogram with superimposed normal curve and a P-P Plot. All seven assumptions were met and the extent to which three independent variables: sexual intervention self-efficacy variable, state anxiety variable, and trait anxiety variable contributed to the total variance of predicting the dependent variable: willingness to initiate sexuality discussions with clients was examined. Examination of the assumptions and statistical analyses is outlined in Chapter 4.

Conclusion

This chapter provided an outline of the methodology used to explore the relationships between sexual intervention self-efficacy, state anxiety, trait anxiety, and willingness to initiate sexuality discussions with clients among MHCPs. This chapter re-introduced the purpose of the study, explained the study rationale, target population, procedures, instrumentation, and research design. This study explored areas of the literature that have not yet been investigated. The results from this study provide additional research about MHCPs that ma provide insight into the influences related to a MHCP's willingness to engage in sexuality discussions with clients and ultimately contribute to expanded counselor education curricula.

CHAPTER 4

RESULTS

Introduction

This chapter describes the findings of the non-experimental, multiple linear regression, quantitative study conducted to explore the relationships between sexual intervention self-efficacy, state anxiety, and trait anxiety. A secondary purpose of this study was to explore whether self-efficacy, state anxiety, and trait anxiety predicted the extent to which MHCPs discussed sexuality with clients.

This chapter also includes discussion outlining that the statistical analyses conducted were consistent with correlational and prediction methodology and how the analyses utilized addressed the research questions. Additionally, each section of this chapter discusses data collection processes, descriptive statistics, as well as the statistical analysis and findings for each research question.

Data Collection

Data collected for this study included a demographic questionnaire (Appendix C) and four instruments: 1) Sexual Intervention Self-Efficacy Questionnaire (SISEQ; Appendix D); State-Trait Anxiety Inventory (STAI) subscales of 2) Form Y1 (S-Anxiety) and 3) Form Y2 (T-Anxiety); Sexuality Discussions with Clients Scale (SDCS; Appendix E). The instruments and demographic questionnaire were converted to an online format for electronic access using Qualtrics (Qualtrics, Provo, UT; http://www.qualtrics.com). The participants were recruited by a simple random sampling technique. A total of 910 invitation letters that included a hyperlink and a QR code to the online survey were sent out to randomly selected professionals from each license type (455 LPCCs and 455 LMFTs). The online survey was available February 19, 2021

and was closed on April 10, 2021. The introductory letters were mailed at different time intervals due to challenges with obtaining responses. Given that only work addresses were provided by each respective licensing board, it is suspected that the pandemic likely contributed to low response rates as most MHCPs were working remotely from home. Initially, 300 letters were mailed. Two weeks following, an additional 100 letters were mailed. Finally, after two more weeks, an additional 510 letters were mailed. The determined sample size necessary to meet the effect, power, and alpha for this study was 62 based on a power of .80, medium effect size equal to $f^2 = .15$, and a significance level of .10. To plan for incomplete responses and potential outliers, the goal sampling frame was 80 prospective participants. At the time the online survey was closed, there were 67 submitted survey responses. However, only 65 (2.98%) of the 67 respondents had completed responses. The final sample consisted of 65 MHCPs who held licenses in either professional clinical counseling (LPCC), marriage and family therapy (LMFT), or dual licensure (LPCC and LMFT).

Data was exported from the online survey software Qualtrics (Qualtrics, Provo, UT; http://www.qualtrics.com) to Microsoft Excel (Microsoft Corporation, 2018) to be cleaned and coded prior to importing into SPSS 27 (IBM Corp., 2020) for data analysis.

Description of the Sample

This section provides the description of the targeted sample for this study and includes summaries of the statistics that describe the data. The sample consists of MHCPs who hold a license to practice independently as either a Licensed Profession Clinical Counselor (LPCC) and/or Licensed Marriage and Family Therapy (LMFT) in the state of Minnesota.

Summaries of Demographic Information

Data was collected to provide comprehensive descriptive statistics. Frequencies and percentage summaries were used to demonstrate the demographic information of MHCPs. The demographic questionnaire (see Appendix C) was created for this current study to examine demographics. The demographic questionnaire inquired about: gender, age, racial ethnicity, religion, sexual orientation, type of licensure, years of professional practice, professional counseling setting, and level of education. A supplemental question inquired about the type of human sexuality training participants received during or after their counselor education. Table 1 presents summaries of the demographic information collected. Table 2 presents the descriptive statistics and reliability of the scales used to measure variables.

Personal Demographics. Fifty-two (80%) of the participants endorsed as female, 9 (13.8%) of the participants endorsed as male, and 4 (6.2%) of the participants did not respond to gender. The majority of the participants (*n* = 30, 46.9%) fell between the age range of 36-50. Eighteen (28.1%) of the participants were in the age range of 26-35; 16 (25%) of the participants were in the age range of 50 and over; and one (1.5%) participant did not respond to the question of age. The race/ethnicity distribution of the sample comprised of 59 (90.8%) White, two (3.1%) Asian, one (1.5%) Black/African American, one (1.5%) Biracial/Multiracial, one (1.5%) selected other endorsing as Jewish, and one (1.5%) preferred not to answer this question. A majority of the participants identified with Christian religious beliefs (*n* = 32, 49.2%); seven (10.8%) of the participants identified an Agnostic belief system; six (9.2%) of the participants identified as spiritual, spiritual but not religious, or Wiccan. The remaining religion distribution of the sample comprised of four (6.2%) Atheist, three (4.6%) Jewish, three (4.6%) no religion, one (1.5%) secular or humanist, one (1.5%) Unitarian or Universalist, and one (1.5%) other; seven (10.8%)

of the participants either preferred not to answer or did not respond to inquiry of religious beliefs. A majority of the participants (n = 53, 81.5%) identified as heterosexual or straight. Five (7.7%) of the participants identified as gay or lesbian; three (4.6%) bisexual; three (4.6%) pansexual; and one (1.5%) preferred not to answer regarding their sexual orientation.

Professional Demographics. Professional demographics in this study included education level, setting in which MHCPs practiced, professional license type, and years practicing professional counseling. Thirty-three (50.8%) of the participants hold a license in professional clinical counseling (LPCC); thirty (46.2%) hold a license in marriage and family therapy (LMFT); two (3.1%) of the participants hold a license in both professional clinical counseling and marriage and family therapy (LPCC and LMFT). The majority of the participants (*n* = 59, 90.8%) endorsed having a master's degree. One (1.5%) of the participants endorsed having a doctoral degree, while two (3.1%) reported having a master's degree and being enrolled in a doctoral-level program, and one (1.5%) reported having a master's degree and being enrolled in another masters-level program. Only one (1.5%) of the participants endorsed having both their master's degree and doctoral degree. Lastly, one participant (1.5%) endorsed being enrolled in a doctorate-level program. The setting distribution of where MHCPs practiced professional counseling comprised 29 (44.6%) in an outpatient agency, 21 (32.3%) in private practice, three (4.6%) in a school-based setting, one (1.5%) in a correctional facility, and two (3.1%) in an inpatient center. Nine (13.8%) of the participants endorsed another setting that was not listed. The years that a MHCP has practiced in professional counseling distribution comprised 24 (36.9%) from six to 10 years, 20 (30.8%) from zero to five years, 9 (13.8%) from 11 to 15 years, and 10 (15.4%) 16 or more years. Two (3.1%) of the participants did not respond to this question.

Supplemental Question. The participants were asked to best describe their human sexuality education and were provided a list of multiple responses that would indicate where and how they received their education, if any. A plurality (*n* = 28, 43.1%) were required to complete a human sexuality course in their graduate program; eleven (16.9%) of the participants endorsed that they did not have any human sexuality education or training; eight (12.3%) of the participants completed a human sexuality course in their undergraduate program; five (7.7%) of the participants endorsed receiving human sexuality education as a component of another required course in their graduate program; four (6.1%) of the participants endorsed completing a human sexuality course as an elective provided by either their graduate program, or a program outside of their graduate training. Finally, nine (13.9%) of the participants endorsed that they had engaged in human sexuality self-learning activities beyond their formal education through either a training (i.e., webinar, conference, seminar) or reading an informative and educational book.

Instrument Description Statistics and Reliability

The descriptive statistics of the scores of the independent variables of sexual intervention self-efficacy, state anxiety, and trait anxiety and the dependent variable of the willingness to discuss sexuality with clients are summarized. Central tendency measures of mean, standard deviation, skewness, and minimum and maximum scores were calculated. Reliability and internal consistency statistics are provided.

Sexuality Discussions with Clients Scale. Harris and Hays (2008) developed the *Sexuality Discussions with Clients Scale* (SDCS) to measure sexuality-related discussions therapists have with their clients. This 9-item scale is intended to measure the presence or absence of sexuality discussions with clients. Each item is a self-report Likert measure that assessed the extent to which therapists have sexual discussions with their clients. The scores of

the Likert response format range from 1 (strongly disagree) to 7 (strongly agree) or 1 (never) to 7 (very often). The higher the scores endorsed indicates that the therapist is more willing to initiate sexuality discussions with their clients. Total scores for this scale can range from nine to 63.

The instructions provided by the author of the scale were used in the scoring of the Sexuality Discussions with Clients Scale (SDCS) format (Harris & Hays, 2008; Hays, 2002). Item 9 was reverse (R) coded in SPSS before analyses were run. After reverse coding the required item, computations (SPSS Transform: Compute Variable) were run to compute the SDCS-total score. To calculate the SDCS total score, all items were totaled and then averaged. The mean (*M*) for 65 participants SDCS was 38.37 with a standard deviation (*SD*) of 10.48. Total scores on the SDCS had a range of 48, with a score of 9 being the minimum and 57 being the maximum. The scale was assessed for reliability and internal consistency in the current study. The scale had good internal reliability and a high level of internal consistency, as determined by a Cronbach's alpha of 0.85.

Sexual Intervention Self-Efficacy Questionnaire. The *Sexual Intervention Self-Efficacy Questionnaire* (SISEQ) was developed by Miller and Byers (2008) to assess beliefs that an individual may hold regarding their ability to address sexuality-related topics with clients. The scale consists of 19 items dispersed among three subscales; (1) the 5-item *Sexual Comfort/Bias* subscale (Comfort/Bias Self-Efficacy); (2) the 7-item *Relaying Sexual Information* subscale (Information Self-Efficacy); and (3) the 7-item *Sex Therapy Skills* subscale (Skills Self-Efficacy). All the items of each subscale require a rating on a 6-point Likert-type scale that ranges from 1 (*strongly agree*) to 6 (*strongly disagree*). Although there are scores of the three subscales, the current study is concerned with the relationship of the total Sexual Intervention Self-Efficacy Scale score. Recommendations for use of the three subscales in future research is

provided in Chapter 5. Total scores will range from 19 to 114. Higher scores represent higher sexual intervention self-efficacy, and lower scores indicated lower sexual intervention self-efficacy.

The instructions provided by the author of the scale were used in the scoring of the Sexual Intervention Self-Efficacy Questionnaire (SISEQ) format (Miller & Byers, 2008). To calculate the total score for the SISEQ, the items were totaled and then averaged. Items 1, 2, 3, 8, 9, and 11 were reverse (R) coded in SPSS before analyses were run. After reverse coding the required items, computations (SPSS Transform: Compute Variable) were run to compute for the SISEQ total score.

The mean (*M*) for 65 participants SISEQ was 79.06 with a standard deviation (*SD*) of 7.89. The SISEQ total scores had a range of 41 with a minimum score of 53 and maximum score of 94. The SISEQ was assessed for reliability and internal consistency in the current study. The scale had an acceptable level of internal consistency, as determined by a Cronbach's alpha of .60.

State-Trait Anxiety Inventory. The *State-Trait Anxiety Inventory* (STAI; Spielberger, 1983) is comprised of two separate self-report forms; the scale for state anxiety (S-Anxiety scale; Form Y-1) that measures the presence and severity of current anxiety symptoms, and the scale for trait anxiety (T-Anxiety scale; Form Y-2) that measures generalized propensity to be anxious.

S-Anxiety scale. The S-Anxiety scale has 20 items that each include a four-point Likert-type scale that are anchored from 1 (*not at all*) to 4 (*very much so*) that assesses feelings of apprehension, tension, nervousness, and worry, and scores of the measure will increase as response to perceived danger and psychological stress increase. The total score for the S-Anxiety scale range from 20 to 80. Higher scores on the S-Anxiety scale indicate higher state anxiety. Lower scores on the S-Anxiety scale indicate lower state anxiety.

The instructions provided by the STAI – Adult Manual © were used in the scoring of the S-Anxiety scale (Spielberger, 1983-2020). Items 3, 4, 6, 7, 9, 12, 13, 14, 17, and 18 were reverse (R) coded in SPSS before analyses were run. After reverse coding the required item, computations (SPSS Transform: Compute Variable) were run to compute the S-Anxiety total score. To calculate the S-Anxiety total score, all items were totaled and then averaged. S-Anxiety scores indicated a mean (M) of 30.78 and a standard deviation (SD) of 7.81. The S-Anxiety total scores had a range of 31, with a minimum score of 20 and a maximum score of 51. The S-Anxiety scale was assessed for reliability and internal consistency in the current study. The S-Anxiety scale had good internal reliability and a high level of internal consistency, as determined by a Cronbach's alpha of .91.

T-Anxiety scale. The T-Anxiety scale has 20 items that each include a four-point Likert-type scale that are anchored from 1 (*almost never*) to 4 (*almost always*) that assess anxiety-proneness, which will differ between individuals with tendencies to perceive stressful situations as dangerous or threatening, responding to such situations with elevations in the intensity of S-Anxiety. The total score for the T-Anxiety scale range from 20 to 80. Higher scores on the T-Anxiety scale indicate higher trait anxiety. Lower scores on the T-Anxiety scale indicate lower state anxiety.

The instructions provided by the STAI – Adult Manual © were used in the scoring of the T-Anxiety scale (Spielberger, 1983-2020). Items 2, 4, 5, 8, 9, 11, 12, 15, 17, 18, and 20 were reverse (R) coded in SPSS before analyses were run. After reverse coding the required item, computations (SPSS Transform: Compute Variable) were run to compute the T-Anxiety total score. To calculate the T-Anxiety total score, all items were totaled and then averaged. The mean (*M*) score for T-Anxiety scale was 32.72, with a standard deviation (*SD*) of 8.01. The T-Anxiety

scale total score was assessed for reliability and internal consistency in the current study. As determined by a Cronbach's alpha of .91, this scale demonstrated good internal reliability and high internal consistency.

Data Analysis and Results

This section presents the research questions examined in this study, including data analysis and results. The current study conducted a correlational analysis to explore the relationships between MHCP's sexual intervention self-efficacy, state anxiety, and trait anxiety. The analysis determined the strength and direction of the relationships between sexual intervention self-efficacy and state anxiety, sexual intervention self-efficacy and trait anxiety, and state anxiety and trait anxiety. Additionally, the current study conducted a multiple linear regression analysis to determine the extent to which sexual intervention self-efficacy, state anxiety, and trait anxiety predicted MHCP willingness to discuss sexuality with clients they counsel. This analysis determined whether sexual intervention self-efficacy, state anxiety, and trait anxiety influence a MHCP's willingness to have sexuality discussions with clients.

Research Question 1 (RQ1)

Is there a relationship between sexual intervention self-efficacy (as measured by SISEQ), state anxiety (as measured by STAI), and trait anxiety (as measured by STAI) among mental health counseling professionals (MHCPs)?

$H1_0$: There are no significant relationships between sexual intervention self-efficacy (SISEQ total score), state anxiety (STAI-S total score), and trait anxiety (STAI-T total score) among mental health counseling professionals (MHCPs).

$H1_a$: There are significant relationships between sexual intervention self-efficacy (SISEQ total score), state anxiety (STAI-S total score), and trait anxiety (STAI-T total score) among mental health counseling professionals (MHCPs).

A two-tailed Pearson's Product-Moment (*r*) correlational analysis was used to examine the relationship between sexual intervention self-efficacy, state anxiety, and trait anxiety. This research question examined the correlation between three independent variables: one sexual intervention self-efficacy variable (SISEQ total score), one state anxiety variable (S-Anxiety scale total score), and one trait anxiety variable (T-Anxiety scale total score), to determine if there was a relationship between paired variables. The Pearson's Product-Moment correlation generates a coefficient (*r*) and the value of the coefficient ranges from -1 to +1, with 0 (zero) indicating whether a relationship is present, and the magnitude and direction of the relationship (Laerd Statistics, 2018). A coefficient that is between 0.5 and 1.0 would indicate a strong correlation; a coefficient between 0.3 and 0.5 would indicate a moderate correlation; while a coefficient that is between 0.1 and 0.3 would indicate a small correlation (Cohen, 1988).

A Pearson correlation matrix analysis was conducted to assess the relationships between sexual intervention self-efficacy, state anxiety, and trait anxiety. Sixty-five participants were recruited. Preliminary analyses showed the relationships between paired variables to be linear with all variables normally distributed by visual inspection for skewness and kurtosis on a scatterplot. There were no outliers. The Shapiro-Wilk statistic contradicted visual inspection, indicating that the variables were not normally distributed, the decision was made to run a Pearson's correlation because the test is somewhat robust to deviations from normality (Laerd Statistics, 2018). The results of this analysis indicated several statistically significant

relationships. Table 3 provides a summary of the results. These relationships, beginning with the correlations between sexual intervention self-efficacy and state anxiety are discussed below.

Sexual intervention self-efficacy and state anxiety. The results of a correlational analysis indicated that there is a statistically significant, moderate negative relationship between sexual intervention self-efficacy and state anxiety $r(65) = -.39$, $p < .001$. This finding suggests that as sexual intervention self-efficacy increases, state anxiety decreases. The coefficient of determination indicated that state anxiety statistically explained 16% of the variability in sexual intervention self-efficacy. This finding indicates that the null hypothesis is rejected.

Sexual intervention self-efficacy and trait anxiety. The results of a correlational analysis indicated that there is a statistically significant, moderate negative relationship between sexual intervention self-efficacy and trait anxiety $r(65) = -.30$, $p = .014$. This finding suggests that as sexual intervention self-efficacy increases, trait anxiety decreases. The coefficient of determination indicated that trait anxiety statistically explained 9% of the variability in sexual intervention self-efficacy. This finding indicates that the null hypothesis is rejected.

State anxiety and trait anxiety. The results of a correlational analysis indicated that there is a statistically significant, strong positive relationship between state anxiety and trait anxiety $r(65) = .75$, $p < .001$. This finding suggests that as state anxiety increases, trait anxiety increases. The coefficient of determination showed that state anxiety statistically explained 56% of the variability in trait anxiety. Although this finding demonstrates a significantly positive correlation, and while state anxiety and trait anxiety are distinct constructs, this finding is not surprising (Spielberger, 1983). Trait-State Anxiety Theory purports that there are higher correlations between S-Anxiety and T-Anxiety in social evaluative situations (Spielberger, 1966, 1972). Further, state and trait anxiety correlations have been reported to be slightly higher when

the STAI scales are given in the same testing session (Spielberger, 1983), which in the case of the study, the T-Anxiety scale was administered immediately following the S-Anxiety scale. This finding indicates that the null hypothesis is rejected.

Research Question Two (RQ2)

To what extent do sexual intervention self-efficacy (as measured by SISEQ), state anxiety (as measured by S-Anxiety scale), and trait anxiety (as measured by T-Anxiety scale) predict willingness to discuss sexual issues with clients (as measured by SDCS) among mental health counseling professionals (MHCPs)?

$H2_0$: Sexual intervention self-efficacy (SISEQ total score), state anxiety (S-Anxiety total score), and trait anxiety (T-Anxiety total score) will not significantly predict willingness to discuss sexual issues with clients (SDCS total score) for mental health counseling professionals (MHCPs).

$H2_a$: Sexual intervention self-efficacy (SISEQ total score), state anxiety (S-Anxiety total score), and trait anxiety (T-Anxiety total score) will significantly predict willingness to discuss sexual issues with clients (SDCS total score) for mental health counseling professionals (MHCPs).

A standard multiple linear regression analysis was conducted to examine whether the independent variables - sexual intervention self-efficacy, state anxiety, and trait anxiety predicted the dependent variable - MHCP's willingness to have sexuality discussions with clients. Additionally, a regression analysis was used to determine the relative contribution that each variable sexual intervention self-efficacy, state anxiety, and trait anxiety contributed to the total variance that was explained by MHCPs willingness to discuss sexuality with clients.

Statistical analyses were conducted to confirm that the assumptions of a multiple regression model were met prior to conducting the multiple regression analysis. Linearity was assessed by regression plots and a plot of studentized residuals against the predicted values, which visual inspection of the plots indicated that the assumption of linearity was met. There was independence of residuals, as assessed by a Durbin-Watson statistic of 1.730. Homoscedasticity was present as assessed by visual inspection of a plot of studentized residuals against unstandardized predicted values. Multicollinearity problems were not demonstrated as tolerance values were greater than 0.1. There was one case that demonstrated studentized deleted residuals were greater than $\pm$3 standard deviations. However, the outlier was not removed, rather noted in case it had a large leverage value. There was one leverage value greater than 0.2, which was recorded for later determination that leads to high influence. There were no values for Cook's distance above 1, indicating that there are no cases that would be considered influential. The assumption of normality was met by visual inspection of a Histogram, P-P Plot and Q-Q Plot.

The multiple regression model was analyzed at the .10 level of significance. An independent variable is a significant predictor of the dependent variable if the *p*-value is equal to or less than the level of significance. The regression analysis indicated that sexual intervention self-efficacy, state anxiety, and trait anxiety statistically significantly predicted willingness to discuss sexuality with clients $F(3, 61) = 3.35$, $p = .025$. This indicated that the regression model did have an acceptable model fit. R^2 for the overall model was 14.2% with an adjusted R^2 of 9.9%, a medium size effect according to Cohen (1988). H_{02} stated that there would be statistically significant predictive relationships between the independent variables: sexual intervention self-efficacy, state anxiety, and trait anxiety and the dependent variable: MHCP's willingness to have sexuality discussions with clients. Regression analyses indicated that sexual

intervention self-efficacy was the only independent variable that added statistically significantly to the prediction ($\beta = 0.534$, $t = 3.112$, $p < .005$). Therefore, the null hypothesis was rejected.

Post Hoc Analysis

The current study conducted a post hoc power analysis in G*power to determine the power of the sample size. The post hoc power analysis should have at least a value of 0.8 to ensure that the sample is significant. A power of 0.8 is commonly used in quantitative analysis (Field, 2013). The power analysis was conducted to determine if 65 participants who completed all instruments was sufficient. The results of a post hoc power analysis of a linear multiple regression involved three predictors with the actual sample size of 65, an effect size of medium (0.15), and an alpha level of 0.10 result to a power of 0.81. This confirmed that the final sample size of 65 was acceptable to reach the necessary power of 80% in a quantitative analysis.

Conclusion

In summary, this chapter provided information about the data collection processes, descriptive statistics, and results of statistical analyses. Two research questions and two related hypotheses were originated for the current investigation. Statistical analyses included the Pearson's Product-Moment correlation and standard multiple linear regression. The Pearson's r calculation determined that there was a significant, positive relationship between state anxiety and trait anxiety. Additionally, there were significant, negative relationships between sexual intervention self-efficacy and state anxiety, as well as sexual intervention self-efficacy and trait anxiety. When examined collectively by a multiple regression model, it was determined that sexual intervention self-efficacy predicted MHCPs' willingness to discuss sexuality with clients. In-depth discussion of the findings, implications for practice, limitations, and recommendations for future research are presented in Chapter 5.

CHAPTER 5

DISCUSSION

Introduction

Sexuality is a core element of the human experience throughout life, encompassing sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction (WHO, 2006). However, sex has long held a taboo status in American society, with generational messages about what is appropriate or not appropriate to discuss, instilling schemas of embarrassment and shame (Hipp & Carlson, 2019; Wilson, 2017). Despite the fundamental aspect that sexuality has in human life, client concerns related to sexuality are not being addressed in mental health counseling (Buehler, 2014; Southern & Cade, 2011). Previous research has demonstrated that this disparity exists for a number of reasons, which includes that MHCPs did not receive adequate training or education in their graduate programs. Other predictors consistently have included comfort with sexuality (Arnold, 1980; Cupit 2010; Harris & Hays, 2008), attitudes about sex and sexuality (Cupit, 2010; Russell, 2012), self-efficacy (Hipp & Carlson, 2019; Miller & Byers, 2008, 2012), supervision experiences (Cupit 2010; Harris & Hays, 2008; Moore, 2018); clinical experience (Moore, 2018), and age (Cupit, 2010; Miller & Byers, 2012; Traeen & Schaller, 2013). The literature reviewed for this study indicated that there was a prevalence of research about various factors influencing the presence of sexuality discussions (Cupit, 2010; Harris & Hays, 2008; Miller & Byers, 2008; 2012). However, the research examining the relationship between sexual intervention self-efficacy and MHCPs' willingness to discuss sexuality concerns with clients has been limited to two studies (Miller & Byers, 2008; 2012), and no research to date has investigated the potential influence of state anxiety and trait anxiety on MHCPs' willingness to initiate sexuality discussions with clients.

With the incidences of client issues related to sexuality, MHCPs should be competent and willing to address these issues.

The purpose of this study was to contribute to the literature associated with factors that influence MHCPs' willingness to address sexuality. Furthermore, this current study intends to provide counselor educators with descriptive and empirical evidence informing curricula for professional identity development of CITs. This study explored the relationships between sexual intervention self-efficacy, state anxiety, and trait anxiety. Additionally, this study examined the extent to which state anxiety, trait anxiety, and sexual intervention self-efficacy influence a MHCPs' willingness to initiate sexuality discussions with clients.

This chapter discusses the results of the current study and these results provide relevance to the existing literature. Specifically, this chapter will include sections that discuss the summary of the results in context of the research problem, the purpose of the study, and research questions and hypotheses, conclusions based on the results, limitations of the study, implications for practice, and recommendations for future research. Finally, this chapter highlights contributions of the current study.

Summary of Results

A quantitative non-experimental survey design with correlational and standard multiple regression analyses was selected as the most appropriate methodology with respect to the purpose of this study. A sample of 65 MHCPs (LPCCs and LMFTs) completed an online survey that collected demographic information and included responses to the Sexual Intervention Self-Efficacy Questionnaire (SISEQ; Miller & Byers, 2008)), the State-Trait Anxiety Inventory (STAI; Spielberger, 1983), and the Sexuality Discussions with Clients Scale (SDCS; Hays, 2002) with the purpose of gathering data that described the sample of MHCPs' sexual

intervention self-efficacy, state anxiety, trait anxiety, and the willingness to discuss sexuality with clients. The first finding indicated a significant positive relationship between state anxiety and trait anxiety, and significant negative relationships between both sexual intervention self-efficacy and state anxiety and sexual intervention self-efficacy and trait anxiety. Additionally, the findings suggested that sexual intervention self-efficacy significantly positively predicted a MHCP's willingness to discuss sexuality with clients.

The research questions for the study were as follows:

RQ1. Is there a relationship between sexual intervention self-efficacy (as measured by SISEQ), state anxiety (as measured by S-Anxiety scale), and trait anxiety (as measured by T-Anxiety scale) among mental health counseling professionals (MHCPs)?

A descriptive correlational design was used to analyze the first research question. A Pearson's *r* correlation test yielded statistically significant results between all the independent variables: Sexual intervention self-efficacy total score scale and state anxiety score scale (r = -.39, $p < .001$); Sexual intervention self-efficacy total score and trait anxiety total score (r = -.30, p = .014); and state anxiety total score scale and trait anxiety total score (r = .75, $p < .001$).

RQ2. To what extent do sexual intervention self-efficacy (as measured by SISEQ), state anxiety (as measured by S-Anxiety scale), and trait anxiety (as measured by T-Anxiety scale) predict willingness to discuss sexual issues with clients (as measured by SDCS) among mental health counseling professionals (MHCPs)?

A standard multiple regression analysis was used to answer research question two. The multiple regression model statistically significantly predicted MHCPs' willingness to discuss sexuality with clients, $F(3, 61) = 3.354$, p = .025, adj. R^2 = .099. Of the three independent variables analyzed, sexual intervention self-efficacy added statistically significantly to the

prediction, $p < .005$. On the other hand, state anxiety and trait anxiety did not add statistically significantly to the prediction of MHCPs' willingness to discuss sexuality with clients.

Discussion of Results

This study was guided by the primary research question designed to examine the extent MHCP sexual intervention self-efficacy, state anxiety, and trait anxiety predict willingness to discuss sexuality with clients among MHCPs. However, the preliminary investigation was to explore the relationships between the independent variables and will first be discussed in this section, followed by discussion of the results of the regression analysis.

Sexual Intervention Self-Efficacy, State Anxiety, and Trait Anxiety

One of the findings of this study indicate significant relationships between the total scores of the SISEQ scale, the STAI T-Anxiety scale, and the STAI S-Anxiety scale. Details of the correlations are addressed in this section.

The first significant negative correlation found in this study indicated that as the total scores of the SISEQ increased, the total scores of the S-Anxiety scale decreased. The result of this analysis suggests that an MHCP who believes they are competent in addressing sexuality concerns with clients might not experience anxious states. These results suggest that the more sexual intervention self-efficacy that a MHCP believes they have, the less state anxiety they might possess. Similarly, the second significant negative correlation indicated that as the total scores of the SISEQ increased, the total scores of the T-Anxiety scale decreased. The same concept could be applied to this finding, in that, the more sexual intervention self-efficacy that a MHCP believes they have, the less prone they are to sensitivity and anxious states. These two findings for this current study, although the first to use these instruments and constructs in research together, resonates with previous literature indicating a relationship between self-

efficacy and anxiety (Bandura, 1956; 1977; 1993; Larson, 1998). Self-efficacy is defined as "beliefs in one's capabilities to organize and execute the courses of actions required to produce given attainments" (Bandura, 1997, p. 3). Further, sexual intervention self-efficacy is described as a therapists' confidence to appropriately address sexual concerns with their clients (Miller & Byers, 2008) The state anxiety factor was found to include a transitory state or condition that varied and fluctuated over time and included physiological signs of arousal. The trait anxiety factor, however, was reported to be comprised of stable individual differences within an enduring personality characteristic (Cattell & Scheier, 1961). Due to the interpersonal nature of psychotherapy, a MHCP's personality traits, such as anxiety, were viewed as an important variable in the determination of counseling effectiveness (Bandura, 1956; Bandura et al., 1960). Bandura (1956) interpreted the finding of a significant negative correlation between anxiety and competence as suggesting that a therapist's personality, such as anxiety, may facilitate or impede their attempts to apply therapeutic procedures. Bandura's (1983) theory of self-efficacy advances that individuals who perceive themselves as ineffective in their ability to cope with potentially aversive events (i.e., self-efficacy evaluations), can generate fear (Bandura, 1983). In contrast, if individuals have beliefs about their ability to exercise control over aversive events, they do not fear them. In their study, Miller and Byers' (2008) explored the relationships between several variables including sexual intervention self-efficacy, sex anxiety, sexual attitudes, and willingness to initiate discussions with clients about sexual problems and concerns, among psychologists. These researchers did not find a relationship between sex anxiety and sexual intervention self-efficacy. However, despite the literature affirming the role of anxiety in the development of self-efficacy (Bandura, 1997), it was suggested that the sex anxiety measure was associated more with a participants' feelings of their own sexuality, instead of assessing anxiety

as it pertains to dealing with clients' sexual problems and concerns. It was further proposed that general anxiety may be more significantly correlated than sexually specific anxiety and that future research should examine the relationship between anxiety and discussing sexuality issues with clients (Miller & Byers, 2008). This study did, in fact, analyze the relationship between general anxiety, through the STAI instrument and focused on both general state and trait anxiety, and sexual intervention self-efficacy; the findings demonstrated a statistically significant correlation. However, the results indicate a more moderate relationship between sexuality intervention self-efficacy and state anxiety as compared to trait anxiety.

The third significant correlation found in this study was between the S-Anxiety scale and the T-Anxiety scale. This suggests that MHCPs with an anxious state might exhibit chronic and pathological proneness or sensitivity to anxious states. Although the correlation between these STAI scales was found to be very high, this finding was not surprising. There is extensive empirical evidence confirming that the State-Trait Anxiety Inventory (STAI; Spielberger, 1983) was developed to measure an individual's state anxiety (S-Anxiety; Form Y-1) and trait anxiety (T-Anxiety; FormY-2) as distinct constructs, but are highly correlated (Spielberger, 1983). Trait-State Anxiety Theory purports that there are higher correlations between S-Anxiety and T-Anxiety in social evaluative situations (Spielberger, 1966, 1972). Further, state and trait anxiety correlations have been reported to be slightly higher when the STAI scales are given in the same testing session (Spielberger, 1983), which in the case of the study, the T-Anxiety scale was administered immediately following the S-Anxiety scale. If administered together, the scales are recommended to be administered in this order (Spielberger, 1983). Additionally, as separate constructs through empirical examination of anxious states versus anxious traits, instrument development confirmed noncollinearity (Spielberger, 1983).

In summary, the current study rejected the null hypothesis stating that there would be no statistically significant relationship between sexual intervention self-efficacy, state anxiety, and trait anxiety.

Predictors of Willingness to Discuss Sexuality with Clients

A multiple linear regression analysis was conducted to examine the extent sexual intervention self-efficacy, state anxiety, and trait anxiety predicted a MHCP's willingness to discuss sexuality with clients. The regression model determined whether the independent variables had a significant effect on a MHCP's willingness to discuss sexuality with clients. The investigation of the individual variables indicated that sexual-intervention self-efficacy significantly predicted and affected a MHCP's willingness to engage in sexuality discussions with clients. While sexual intervention self-efficacy did predict willingness to engage in sexuality discussions, state anxiety and trait anxiety were not found to significantly predict willingness to engage in sexuality discussions.

The results of the multiple regression indicate that there is a relationship between MHCPs' sexual intervention self-efficacy and the willingness to discuss sexuality with clients. Additionally, these results suggest that some variability in a MHCP's willingness to discuss sexuality with clients might be explained by the beliefs a MHCP holds regarding their ability to address sexuality concerns with clients. The theory of self-efficacy posits that there is a relationship between fear arousal and perceived self-efficacy, and further that individuals who experience higher levels of fear arousal will engage in avoidance behaviors (Harris & Hays, 2008). Previous research examining the relationship between sexual intervention self-efficacy and willingness to discuss sexuality with clients included two studies (Miller & Byers, 2008; 2012) that demonstrated similar results reported in this study. Miller & Byers (2008) analyzed

the relationship between the three subscales of the SISEQ (Skills Self-Efficacy, Information Self-Efficacy, Comfort Self-Efficacy) with a different instrument than the one used in this study that measured the willingness to treat clients who have sexual concerns/problems among clinical psychology graduate students. The study results found positive correlations between different factors of sexual intervention self-efficacy (SISEQ Skills Self-Efficacy subscale, $r = .46$, $p < .001$; SISEQ Information Self-Efficacy subscale, $r = .38$, $p < .001$; SISEQ Comfort Self-Efficacy subscale, $r = .40$, $p < .001$) and the willingness to discuss sexuality concerns with clients. The primary focus of Miller and Byers (2008) study was to better understand the extent that variables predicted the dependent variable sexual intervention self-efficacy; thus, to date there have been no investigations using a regression analysis to compare with the results of this study. Miller and Byers (2012) reported similar findings to this study, showing direct effects of sexual intervention self-efficacy on willingness to treat ($b = .79$, $p < .001$). Further the researchers suggested that psychologists' failure to address sexuality issues with their clients was due to a lack of self-efficacy regarding their assessment and treatment of clients' sexual concerns and problems (Miller & Byers, 2012). The results of previous research in context with this current study, support sexual intervention self-efficacy as a key factor in the extent to which MHCPs address sexuality issues with their clients. With such limited data, it is imperative to further analyze this relationship. The variable of sexual intervention self-efficacy should be considered in the development of counselor education curriculum, contributing to CIT efficacy in addressing sexual issues with clients.

This is the first investigation to explore the relationship between state anxiety and trait anxiety and the willingness to discuss sexuality with clients among MHCPs. Despite the research hypothesis, and literature suggesting the relationship between anxiety and therapeutic behaviors

(Bandura, 1956; Bandura et al., 1960; Yulis & Kiesler, 1983), this study did not confirm that state anxiety and/or trait anxiety would contribute to the prediction of a MHCP's willingness to discuss sexuality with clients. This may be similar to the reports of Miller and Byers (2008) in which that, the researchers discussed that a correlational analysis between sex anxiety and sexual intervention self-efficacy was not appropriate and general anxiety would replace sex anxiety. Whereas, in this study, assessing sex anxiety might make more sense in exploring a relationship with the willingness to address sexuality with clients construct rather than general anxiety. However, the survey design of this study may have influenced the results. It is suggested that future research designs both experimental and qualitative, be conducted to explore this relationship, which may offer more rich data and perhaps control for extraneous factors.

Implications of the Findings

The findings from the current study have several implications for the mental health counseling field, counselor education and training programs, and accrediting boards. The prevalence of sexuality concerns among clients that seek mental health counseling presents unique challenges for MHCPs in both their practice and in their training to develop professional skills and knowledge. An important consideration would be that accrediting boards develop standards for addressing human sexuality in counselor educations programs in order to prepare effective MHCPs. With accrediting boards demonstrating the importance of addressing human sexuality in mental health counseling programs and the impact of sexual health to an individual's overall wellbeing, the taboo will likely decrease, creating a space for willing and competent MHCPs to engage in sexuality discussions with clients.

Failure to address sexuality concerns with clients is problematic because of the key factor that sexuality plays in an individual's sexual health, as well as overall wellbeing. For this reason,

it is imperative for MHCPs to routinely address sexuality concerns (Miller & Byers, 2012). The findings of this study support that sexual intervention self-efficacy is a key factor in the willingness to discuss sexuality with clients. It is suggested that the higher sexual intervention self-efficacy, the more open to accepting rather than referring clients with sexuality concerns, more frequently asking about sexuality concerns during assessment, and more frequently asking about and treating sexuality concerns in counseling a MHCP will be (Miller & Byers, 2012). This suggests that failure to address sexuality concerns with clients may be due to a lack of self-efficacy with regard to assessing and treating clients' sexuality concerns and problems. MHCPs are expected to engage in multiple subskills demonstrating their competence, and on another level, their judgment of these subskills will endorse these performances (Larson & Daniels, 1998). Self-efficacy is concerned with these judgments, or beliefs an individual has about how well they can perform these tasks. Bandura (1997) posited that there are four factors contributing to the construction of an individual's self-efficacy. These four factors include mastery experiences, vicarious experiences, verbal persuasion, and physiological and affective states (Bandura, 1997). Miller and Byers (2012) found in their study that sexuality-specific education and training beyond formal graduate counselor programs directly enhanced sexual intervention self-efficacy. This current study highlights the necessity for MHCPs to demonstrate higher levels of sexual intervention self-efficacy in order to increase their willingness to address sexuality with clients. If this is the case, then counselor educators can be informed to develop and implement curricula directed towards improving a CITs' sexual intervention self-efficacy.

Counselor education programs can develop sexual intervention self-efficacy by increasing opportunities for mastery experiences that allow CITs to enact therapeutic behaviors that practice sex therapy techniques and impart sexuality information, as well as space to reflect

on their comfort and bias in practicing these skills. Feedback regarding CITs performances of enacting sexual intervention behaviors should also be included because of the role that verbal persuasion has in the development of self-efficacy. Other aspects of self-efficacy development suggest the contribution of vicarious experiences in counselor education (Harris & Hays, 2008). Therefore, it is suggested to include opportunities for CITs to observe both peers and supervisors enacting sexuality discussions with clients. The final factor to self-efficacy development, physiological and emotional states, would best be addressed by means of measuring a CITs arousal response during enactments of sexual intervention skills, or while observing peers' and supervisors' sexuality discussions with clients. Dependent upon the physiological and emotional states during performances, CITs can work towards desensitizing and reducing their arousal that negatively impacts their self-efficacy development.

This study further informs the counselor education field, in that, summary data has affirmed that most of the participants in this sample did not receive formal human sexuality training in their graduate programs. A little over half (n = 37, 57%) of the MHCPs endorsed that they received some form of human sexuality education in their graduate programs, whether it had been a required course, an elective, or a component of another required course. While the other half of the sample (n = 28, 43%) indicated that they did not receive human sexuality education specifically in the graduate program. This means that they either completed a course in their undergraduate preparation, engaged in their own continuing education through a training activity or reading a book, or have had no sexuality education at all. This finding is concerning, as it indicates that human sexuality education is lacking in counselor education graduate programs, despite the potential abundance of times a MHCP encounters sexuality issues in counseling. This supports the literature that has reported similar statistics that human sexuality

education is not a requirement for most counselor training programs. Due to this disparity, it is suggested that counselor education programs include a stand-alone human sexuality course that includes all components of knowledge and skills development. There is a large array of sexuality content that should be discussed and taught in order for CITs to develop needed competence in the area of sexual intervention. In addition, infusing aspects of human sexuality in other courses is recommended. Thus, accreditation boards, such as CACREP and COAMFTE, should include standards to increase human sexuality in counselor education programs.

For those MHCPs that did not receive a human sexuality education, it is suggested that they seek continuing education units in the subject of human sexuality. This would need to be informed by licensure boards who manage the credentialing of licensed professionals, and a standard created to ensuring that MHCPs are well-versed in all aspects of health. Miller and Byers (2008; 2012) reported that continuing education activities related to human sexuality training had a strong relationship with sexual intervention self-efficacy and the willingness of MHCPs to discuss sexuality with clients. Important continuing education activities to enhance self-efficacy should include reviewing the literature, examining the self as therapist, creating a sexuality genogram, and assessing attitudes, values, and beliefs regarding sexuality.

Additionally, descriptive statistics for the variables assessed, including means and standard deviations, further informs some implications regarding the mental health counseling field. The mean (M) total score for the SDCS scale (M = 38.37, SD = 10.48) indicates that the MHCPs in this sample may not necessarily be willing to discuss sexuality with clients. The SDCS has a possible range of 54, with nine being the lowest and 63 being the highest, a score of 38 is nearly the middle value of whether a MHCP is willing or unwilling to engage in sexuality discussions. This statistic does not infer most of the sample, but it is indicative of an average

response. This could suggest that MHCPs are generally not very willing to discuss sexuality with clients. This confirms the literature suggesting that MHCPs may not be addressing sexuality with their clients despite the prevalence of client needs (Harris & Hays, 2008; Miller & Byers, 2012).

Although this study was exploratory, and a pilot in examining the influence that state anxiety and trait anxiety have on MHCPs' willingness to discuss sexuality with clients, the results demonstrate meaningful outcomes, especially related to the predictive power of sexual intervention self-efficacy. The taboo nature of sex and sexuality has hindered the inclusion of human sexuality education in counselor training. This study has provided evidence to inform how the findings can positively impact the mental health counseling field, counselor education, and accreditation boards.

Limitations

The current study explored relationships of variables that have not been examined to date, specifically related to state and trait anxiety and MHCP willingness to discuss sexuality with clients.

One limitation is related to the generalizability of the findings. Although the scope in sampling was narrow, which helped to provide data related to certain licensed MHCPs in the state of Minnesota, the sampling was not able to demonstrate an appropriate representation of demographic variables that may be present in other regions of the United States. The intention of choosing the state of Minnesota and utilizing licensing boards rather than association memberships was to narrow the inclusion criteria process, that specifically focused on clinical mental health counseling practices that would assumingly demonstrate counseling behaviors that this study focused upon. The sample lacked in diverse demographics, showing predominately White, Christian, and cisgender female statistics. Hence, the results of this study cannot be

generalized in context to a larger population. Future studies may include broader populations, including more diverse regions of the United States, inclusive of differing professional licensures, such as clinical social workers or psychologists, and MHCPs working in a variety of roles and settings.

In addition to generalizability limitations, a second limitation was the sample size. Although the study was exploratory and set at a significance of .10 only requiring a sample of 62, quantitative research methodology usually requires a larger sample size, which would have allowed for more power in analysis. The current state of affairs in the United States, with a pandemic that limited contact among individuals, may have increased fatigue of MHCPs, and/or the provision of online counseling may have posed a barrier for individuals to complete surveys. The response rate of approximately 7.4%, was alarmingly low in comparison to typically expected response rates of 20%. The post hoc analysis determined that the sample size was appropriate for a significance level of .10, power of .80, and effect size of .15. The null hypothesis for research question one was rejected, and the null hypothesis for research question two was rejected. Although the statistically significant findings demonstrated a *p*-value below .05, the small sample size showed inadequate power of the statistical test ($1- \beta = .72$), which would detect a true difference if one really existed that would lead to a type II error. Again, this was an exploratory study that demonstrated statistically significant results, although taken in caution, can benefit and inform future research.

Another limitation to this study is the self-report nature of the survey. Participants were solicited to complete the survey in whichever environment they were in at the time. This could contribute to confusion about vague questions that were unable to be clarified had they been in a controlled environment. Self-reporting contributes to the possibility of false reports. This means,

that participants could potentially inflate or underscore their responses on personally challenging variables measured in the study. This could be particularly true for measuring occurrences of sexuality discussions with clients, beliefs about performances in counseling clients with sexuality concerns, and experiences with anxiety.

An additional methodological weakness in this research concerns validity and reliability. The instruments that were used to measure the dependent variable, Sexuality Discussions with Clients Scale (SDCS), and the independent variable, Sexual Intervention Self-Efficacy Questionnaire (SISEQ) demonstrate limitations associated to their validity and reliability. Although there were several instruments used in previous research that measured willingness to discuss sexuality with clients, there was no indication that the SDCS or the other instruments were extensively developed to demonstrate that they measure what is intended to be measured, as well as perform as it is designed to perform. It is recommended that future studies focus on the development of a valid instrument that appropriately assesses the construct of sexuality discussions with clients. Additionally, the SISEQ demonstrated limitations related to reliability. Previous research that utilized the SISEQ demonstrated much higher internal consistency than the current study. Miller and Byers (2008) reported high internal consistency with Sex Therapy Skills $\alpha = .87$, Relaying Sexual Information $\alpha = .88$, Sexual Comfort/Bias $\alpha = .73$, and Total Sexual Intervention Self-Efficacy Scale $\alpha = .88$. Miller and Byers (2012) and Hayes (2019) demonstrated acceptable internal consistencies on the SISEQ: Sex Therapy Skills $\alpha = .88$, Relaying Sexual Information $\alpha = .82$, Sexual Comfort/Bias $\alpha = .64$, and Total Sexual Intervention Self-Efficacy Scale $\alpha = .92$. However, this study reported internal consistency, although acceptable, as determined by a Cronbach's alpha of .604, very different than previous

research. The small sample size may have contributed to this result, again another limitation to this study.

Recommendations for Future Research

This exploratory study was the first to examine relationships between sexual intervention self-efficacy, state anxiety, trait anxiety, and a MHCPs' willingness to discuss sexuality with clients. Therefore, replication and further exploration of these variables is needed to better understand how these relationships enhance the effectiveness of MHCPs.

Bandura (1993) suggested that anxiety impacted therapeutic behaviors as well as emotional states that contribute to the development of self-efficacy. Most of the research so far has focused on the relationship of internal and external factors and therapeutic behaviors (i.e., education, training, attitude, knowledge), while personality characteristics, such as anxiety, has not been extensively investigated. This study was the first to examine the relationship of anxiety, as measured by the empirically evidenced State-Trait Anxiety Inventory (STAI), and willingness to discuss sexuality with clients. However, results indicated that there was no relationship between state anxiety or trait anxiety with willingness to discuss sexuality with clients. Despite the lack of findings, there is merit in exploring the influence that personality characteristics have on a MHCP's therapeutic behaviors, especially ones that impact client welfare. There is a potential for future research to examine state and trait anxiety as it relates to these variables on a larger scale, in order to add to more empirical evidence supporting the relationships between therapist behaviors when discussing sexuality. There is merit in exploring the effects of personality characteristics on engagement in effective therapeutic behaviors, and future studies are recommended to include more constructs that examine these qualities, including agreeableness, extroversion, introversion, openness, conscientiousness, and neuroticism.

Due to limitations contributed to by the small sample size, including generalizability, reliability, and significance, it is recommended that future research focus on replicating this study with a larger sample. This includes expanding to broader populations, including more diverse regions of the United States, diversifying the recruitment procedures for better accessibility and response rate, and including more variety of roles and settings. Anxiety is an important construct to therapeutic behaviors, and further analyses with a larger sample might contribute to more significant results.

Counselor professional identity development is an important experience from the start of graduate training, through clinical training, and finally professional practice. As such, it would be recommended to explore the trajectory of personality characteristics, such as, anxiety, as well as important learning variables, such as self-efficacy, particularly sexuality intervention self-efficacy, and the relationship to the willingness to discuss sexuality with clients, over time in a longitudinal study.

Due to difficulty in assessing and measuring a MHCP's willingness without being presented with live situations that would challenge them or place them in an experience where they could express what is happening on all cognitive, affective, and psychological levels. It is further recommended that future research replicate this study using in-vivo experimental methods, including qualitative inquiry. This study was exploratory but will lend to future research to make more inferences regarding a rationale for differences among groups.

For this study, the literature related to this research demonstrated scarcity in use of the instrument Sexuality Discussions with Clients Scale. While it was found to contain the most construct validity for the purposes of this study, it is suggested for future research to focus on

and develop an empirically supported instrument to measure the effectiveness of a MHCP's willingness to address, assess, and treat sexuality concerns posed by clients that they counsel.

Conclusion

The problem examined in this study was how factors affect a MHCP's willingness to discuss sexuality with clients. Specifically, to what extent sexual intervention self-efficacy, state anxiety, and trait anxiety predict willingness to engage is sexuality discussions with clients among MHCPs. The purpose of this non-experimental, correlational and regression quantitative study was to determine if relationships existed between sexual intervention self-efficacy, state anxiety, and trait anxiety, and if so, to what extent. Despite literature indicating the abundance of MHCP encounters with sexuality concerns in counseling, it has been consistently demonstrated in previous research that MHCPs may be ill-equipped to address and intervene, or that these discussions are not happening (Bloom et al., 2016; Harris & Hays, 2008; Hays, 2002; Miller & Byers, 2008). Historically, many of the variables investigated in the literature have focused on external factors, despite the potential value of examining anxiety, that may offer greater understanding of the influence of personality characteristics on the apparent reluctance of MHCPs to engage in client concerns related to sexuality. Relatedly, self-efficacy has consistently been found to be a strong correlate and predictor of MHCP performance (Alvarez, 1995; Bandura, 1997). Research has demonstrated a consistent relationship between anxiety and self-efficacy, indicating that lower levels of anxiety correlate with higher levels of self-efficacy. This exploratory study was guided by the primary research question that asked to what extent sexual intervention self-efficacy, state anxiety, and trait anxiety would predict willingness to discuss sexuality with clients among MHCPs. A sample of 65 LPCCs and LMFTs in the state of Minnesota responded to an online survey with the purpose of collecting information about

demographic factors, sexual intervention self-efficacy, anxiety, and willingness to discuss sexuality with clients. The findings of the study suggested that sexual intervention self-efficacy statistically significantly predicted willingness to discuss sexuality with clients among MHCPs, while state anxiety and trait anxiety did not significantly predict willingness to discuss sexuality with clients among MHCPs. The findings supported some aspects of the research problem, such as the role of self-efficacy in relationship to counseling behaviors and effectiveness. However, a majority of the findings added to the literature by including factors such as state anxiety and trait anxiety and extending the literature by including sexual intervention self-efficacy, which was lacking in previous investigations. The current study overcame some limitations initially identified, such as small sample size, influence of self-report measures on validity and reliability issues and generalizing the findings to the larger population.

The findings of this study suggest that advancements can be made in training counselors to be equipped to address sexuality concerns with clients and attain better sexual health. Recommendations for future studies include suggestions based on the findings as well as limitations of the current study. The results of the study answered the purpose of the study, which was two-fold, to explore relationships between sexual intervention self-efficacy, state anxiety, and trait anxiety, and to examine the extent to which sexual intervention self-efficacy, state anxiety, and trait anxiety predict willingness to discuss sexuality with clients among MHCPs. This study was intended to highlight the need for change, as clients will continue to experience concerns related to sexuality. MHCPs should be prepared to address and assist the needs of clients.

References

Alvarez, A. (1995). *Perceptions of fraudulence, counseling self-efficacy, and satisfaction with work* (Publication No. 9532117) [Doctoral dissertation, State University of New York at Albany]. ProQuest Dissertations & Theses Global.

American Association of Marriage and Family Therapy [AAMFT]. (2015). *AAMFT Code of Ethics*. Author.

American Counseling Association [ACA]. (2014). *2014 ACA Code of Ethics*. Author.

American Psychiatric Association [APA]. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Anderson, M. J. (2002). *Counselor comfort with sexual issues* [Unpublished doctoral dissertation]. University of New Orleans.

Anderson, W. (1986). Stages of therapist comfort with sexual concerns of clients. *Professional Psychology: Research and Practice, 17*(4), 352-356. https://doi.org/10.1037/0735-7028.17.4.352

Arnold, R. L. (1980). *A study of the sexual attitudes, knowledge and experience of counselors in training and the effect of these factors on counselor reaction to client sexual concerns* (Publication No. 8028312) [Doctoral dissertation, University of Northern Colorado, Greeley, CO]. ProQuest Dissertations & Theses Global.

Athanasiou, R., and Shaver, P., and Travis, C. (1970). Sex. *Psychology Today*, 39-52. Retrieved from: https://www.psychologytoday.com/us/basics/sex

Bandura, A. (1956). Psychotherapist's anxiety level, self-insight and psychotherapeutic competence. *Journal of Abnormal and Social Psychology, 52*(3), 333-337.

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review, 84*(2), 191-215. https://doi.org/10.1037/0033-295X.84.2.191

Bandura, A. (1982). Self-efficacy mechanism in human agency. *American Psychologist, 37*(2), 122-147. https://doi.org/10.1037/0003-066X.37.2.122

Bandura, A. (1983). Self-efficacy determinants of anticipated fears and calamities. *Journal of Personality and Social Psychology, 45*(2), 464-469. https://doi: 10.1037/0022-3514.45.2.464

Bandura, A. (1986). The explanatory and predictive scope of self-efficacy theory. *Journal of Social and Clinical Psychology, 4*, 359-373.

Bandura, A. (1997). *Self-efficacy: The exercise of control*. Freeman.

Bandura, A., Lipsher, D. H., & Miller, P. E. (1960). Psychotherapist's approach-avoidance reactions to patient's expression of hostility. *Journal of Consulting Psychology, 24*(1), 1-8. https://doi.org/10.1037/h0043403

Bandura, A., Ross, D., & Ross, S. A. (1963). Vicarious reinforcement and imitative learning. *The Journal of Abnormal and Social Psychology, 67*(6), 601-607. https://doi.org/10.1037/h0045550

Barbee, P. W., Scherer, D., & Combs, D. C. (2003). Prepracticum service-learning: Examining the relationship with counselor self-efficacy and anxiety. *Counselor Education & Supervision, 43*(2), 108–119. https://doi.org/10.1002/j.1556-6978.2003.tb01835.x

Barnes, K. L. (2004). Applying self-efficacy theory to counselor training and supervision: A comparison of two approaches. *Counselor Education and Supervision, 44*(1), 56-69. http://dx.doi.org.ezproxy.mnsu.edu/10.1002/j.1556-6978.2004.tb01860.x

Berman, L. A. (1997). *A study of the influence of sexuality education experiences, sexual*

comfort and agency support on social workers' willingness to address client sexual concerns (Publication No. 9718703) [Doctoral dissertation, New York University]. ProQuest Dissertations & Theses Global.

Blalock, K. M., & Wood, S. K. (2015). Women living with serious mental illness: The impact of sexual stigma and sexual wellness on quality of life. *Women & Therapy, 38*(1-2), 77–88. https://doi.org/10.1080/02703149.2014.978218

Bloom, Z. D., Gutierrez, D., Lambie, G. W., & Ali, S. (2016). Counselors' comfort with sexuality, attitudes towards pornography, and propensity to assess and treat client issues related to pornography use. *Journal of Mental Health Counseling, 38*(4), 327-345. https://doi.org/10.17744/mehc.38.4.04

Bogey, L. A. (2008). *Addressing sexuality with clients: A manual for therapists in training* (Publication No. AAI3308670) [Doctoral dissertation, Regent University]. ProQuest Dissertations & Theses Global.

Buehler, S. (2014). *What every mental health professional needs to know about sex.* Springer Publishing.

Cattell, R. B., & Scheier, I. H. (1958). The nature of anxiety: A review of thirteen multivariate analyses comprising 814 variables. *Psychology Report, 4*, 351-388. https://doi.org/10.2466/PR0.4.3.351-388

Cattell, R. B., & Scheier, I. H. (1961). *The meaning and measurement of neuroticism and anxiety.* Ronald Press.

Center for Behavioral Health Statistics and Quality. (2016). *Key substance use and mental health indicators in the United States: Results from the 2015 national survey on drug use and health.* Retrieved from: http://www.samhsa.gov/data/

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences (2nd ed*.). L. Erlbaum.

Cohen, J. (1992). Statistical power analysis. *Current Directions in Psychological Science, 1*(3), 98–101. https://doi.org/10.1111/1467-8721.ep10768783

Commission on Accreditation for Marriage and Family Therapy Education (2017). *COAMFTE Accreditation Standards*. Retrieved from: https://www.coamfte.org/documents/COAMFTE/Accreditation%20Resources/2018%20COAMFTE%20Accreditation%20Standards%20Version%2012%20May.pdf

Council for Accreditation of Counseling and Related Educational Programs. (2016). *2016 CACREP standards*. Retrieved from: http://www.cacrep.org/wp-content/uploads/2018/05/2016-Standards-with-Glossary-5.3.2018.pdf

Creswell, J. W. (2013). *Research design: Qualitative, quantitative, and mixed methods approaches (4th ed.).* Sage.

Cronbach, L. J. (1951). Coefficient alpha and the internal structure of tests. *Psychometrika, 16*(3), 297-334.

Cupit, R.W. (2010). *Counselors' comfort levels and willingness to discuss sexual issues with couples they counsel* (Publication No. 3414807) [Doctoral dissertation, University of New Orleans]. ProQuest Dissertations & Theses Global.

Daniels, J. A. (1997). *The influence of performance feedback and causal attributions upon ratings of counseling self-efficacy* (Publication No. 9736927) [Doctoral dissertation, University of Nebraska, Lincoln]. ProQuest Dissertations & Theses Global.

Daniels, J. A., & Larson, L. M. (2001). The impact of performance feedback on counseling self-efficacy and counselor anxiety. *Counselor Education & Supervision, 41*(2), 120-130. https://doi.org/10.1002/j.1556-6978.2001.tb01276.x

Dermer, S., & Bachenberg, M. (2015). The importance of training marital, couple, and family therapists in sexual health. *Australian and New Zealand Journal of Family Therapy, 36*(4), 492–503. https://doi.org/10.1002/anzf.1122

Diambra, J. F., Pollard, B. L., Gamble, R. M., & Banks, B. P. (2016). Teaching a human sexuality course: What are counseling students thinking? *American Journal of Sexuality Education, 11*(1), 76-91. https://doi.org/10.1080/15546128.2016.1141737

Dupkoski, W. (2012). Sexuality is universal: Implications for using a constructivist approach to sexuality training in counselor education programs. *VISTAS 2012*. Retrieved from: http://www.counseling.org/Resources/Library/VISTAS/vistas12/Article_12.pdf

Ebel, R.L. (1951). Estimation of the reliability of ratings. *Psychometrika 16*, 407–424. https://doi.org/10.1007/BF02288803

Field, A. (2013). *Discovering statistics using IBM statistics* (4th ed.). Sage.

Fisher, N. E. (2019). *Psychologists' engagement in sexuality discussions* (Publication No. 22622487) [Doctoral dissertation, Chicago School of Professional Psychology, Irvine]. ProQuest Dissertations & Theses Global.

Fisher, W. A., Grenier, G., Watters, W. W., Lamont, J., Cohen, M., & Askwith, J. (1988). Students' sexual knowledge, attitudes toward sex, and willingness to treat sexual concerns. *Journal of Medical Education, 63*(5), 379-385. https://doi.org/10.1097/00001888-198805000-00005.

Flaget-Greener, M., Gonzalez, C. A., & Sprankle, E. (2015). Are sociodemographic characteristics, education and training, and attitudes toward older adults' sexuality predictive of willingness to assess sexual health in a sample of US psychologists? *Sexual and Relationship Therapy, 30*(1), 10–24. https://doi.org/10.1080/14681994.2014.948297

Fluharty, L. B. (1996). *The effects of sexual knowledge, professional status, and client gender, on male and female therapists' comfort with client-presented sexual material* (Publication No. AAM9611390) [Doctoral dissertation, University of Akron]. ProQuest Dissertations & Theses Global.

Freud, S. (1920). *A general introduction to psychoanalysis*. Boni and Liveright.

Freud, S. (1924). *Collected papers, Vol. 1*. Hogarth Press.

Freud, S. (1936) *The problem of anxiety.* Norton.

Friedlander. M. L.. Keller. K. E.. Peca-Baker, T. A.. & OIk. M. E. (1986). Effects of role conflict on counselor trainees' self-statements, anxiety level, and performance. *Journal of Counseling Psychology. 33*(1), 73-77. https://doi.org/10.1037/0022-0167.33.1.73

Graham, C. A., & Smith, M. M. (1984). Operationalizing the concept of sexuality comfort: Applications for sexuality educators. *Journal of School Health, 54*(11), 439-442. https://doi.org/10.1111/j.1746-1561.1984.tb08908.x.

Gleser, F., Gottschalk, L. A., & Springer, K. J. (1961). An anxiety scale applicable to verbal samples. *Archives of General Psychiatry, 5*(6), 103-114. https://doi.org/10.1001/archpsyc.1961.01710180077009

Erdfelder, E., Faul, F., & Buchner, A. (1996). GPOWER: A general power analysis program. Behavior Research Methods, *Instruments & Computers, 28*(1), 1-11. https://doi.org/10.3758/BF03203630

Grös, A. (2007). Psychometric properties of the State-Trait Inventory for Cognitive and Somatic Anxiety (STICSA): Comparison to the State-Trait Anxiety Inventory (STAI). *Psychological Assessment*, *19*(4), 369–381. https://doi.org/10.1037/1040-3590.19.4.369

Haag, S. C. (2009). *Psychotherapist factors that impact self-efficacy for working with clients presenting issues related to sexuality and sexual activities* (Publication No. AAI3347219) [Doctoral dissertation, University of Iowa]. ProQuest Dissertations & Theses Global.

Haboubi, N. H. J., & Lincoln, N. (2003). Views of health professionals on discussing sexual issues with patients. *Disability and Rehabilitation*, *25*(6), 291–296. https://doi.org/10.1080/0963828021000031188

Hanzlik, M. P., & Gaubatz, M. (2012). Clinical PsyD trainees' comfort discussing sexual issues with clients. *American Journal of Sexuality Education*, *7*(3), 219–236. https://doi.org/10.1080/15546128.2012.707080

Harris, S. M., & Hays, K. W. (2008). Family therapist comfort with and willingness to discuss client sexuality. *Journal of Marital and Family Therapy*, *34*(2), 239–250. https://doi.org/10.1111/j.1752-0606.2008.00066.x

Hayes, T. U. (2019). *An examination of the effect of professional license type and gender on the self-efficacy and comfort level of counseling skills in addressing sexual issues with clients* (Publication No. 13808141) [Doctoral dissertation, Mercer University]. ProQuest Dissertations & Theses Global.

Hays, K. W. (2002). *The influence of sexuality education and supervision, clinical experience, perceived sex knowledge, and comfort with sexual content on therapists addressing sexuality issues with clients* (Publication No. 3069179) [Doctoral dissertation, Texas Tech University, Lubbock]. ProQuest Dissertations & Theses Global.

Hedgepeth, E. M. (1988). *Sexuality comfort: Its measurement, and relationship to other variables in sexuality education* (Publication No. 8905065) [Doctoral dissertation, The Union for Experimenting Colleges and Universities]. ProQuest Dissertations & Theses Global.

Heiman, J. R. (2002). Sexual dysfunction: Overview of prevalence, etiological factors, and treatments. *The Journal of Sex Research, 39*(1), 73-78. https://doi.org/10.1080/00224490209552124

Hendrick, C., Hendrick, S., & Reich, D. (2006). The brief sexual attitudes scale. *Journal of Sex Research, 43*(1), 76-87. https://doi.org/10.1080/00224490609552301

Hipp, C. J., & Carlson, R. G. (2019). Comfort in treating sexual problems: Current training and counselor self-efficacy. *The Family Journal, 27*(2), 105–114. https://doi.org/10.1177/1066480719835342

Holt, E. B. (1931). *Animal drive and the learning process: an essay toward radical empiricism*. Holt.

Horst, P. (1949). A generalized expression for the reliability of measures. *Psychometrika 14*, 21–31. https://doi.org/10.1007/BF02290137

Houghton, L.L. (2018). *Let's talk about sex: Effects of a training workshop on clinician sexual attitudes, knowledge, and engagement in sexual discussions with clients* (Publication No. 10831566) [Doctoral dissertation, University of Wisconsin, Madison]. ProQuest Dissertations & Theses Global.

Humphrey, K. M. (2000). Sexuality counseling in counselor preparation programs. *The Family Journal: Counseling and Therapy for Couples and Families, 8*(3), 305-308. https://doi.org/10.1177/1066480700083018

Jaramillo, A. M. (2017). *Counselor education trainees' comfort and willingness to discuss sexuality issues with clients* (Publication No. 10410516) [Doctoral dissertation, University of Florida]. ProQuest Dissertations & Theses Global.

Juergens, M. H., Smedema, S. M., & Berven, N. L. (2009). Willingness of graduate students in rehabilitation counseling to discuss sexuality with clients. *Rehabilitation Counseling Bulletin, 53*(1), 34-43. https://doi.org/10.1177/0034355209340587

Kalra, G., Ventriglio, A., & Bhugra, D. (2015). Sexuality and mental health: Issues and what next? *International Review of Psychiatry*, *27*(5), 463–469. https://doi.org/10.3109/09540261.2015.1094032

Kocarek, C. E. (2001). *Understanding the relationships among counseling self -efficacy, anxiety, developmental level, coursework, experience, and counselor performance* (Publication No. 3020231) [Doctoral dissertation, Western Michigan University]. ProQuest Dissertations & Theses Global.

Koth, K. H. (2019). *Counseling self-efficacy and counselor-in-training anxiety: The moderating role of mindfulness* (Publication No. 22623373) [Doctoral dissertation, Mercer University]. ProQuest Dissertations & Theses Global.

Laerd Statistics (2018). *Statistical tutorials and software guides*. Retrieved from https://statistics.laerd.com/

Laumann, E. O., Paik, A., & Rosen, R. C. (1999). Sexual dysfunction in the United States: prevalence and predictors. *JAMA: Journal of The American Medical Association, 281*(6), 537-544. https://doi.org/10.1001/jama.281.6.537

Larson. L. M., & Daniels. J. A. (1998). Review of the counseling self-efficacy literature. *The Counseling Psychologist, 26*(2), 179-218. https://doi.org/10.1177/0011000098262001

Larson. L. M.. Suzuki. L. A.. Gillespie. K. N.. Potenza. M. T.. Bechtel. M. A.. & Toulouse. A. L. (1992). Development and validation of the Counseling Self-Estimate Inventory. *Journal of Counseling Psychology, 39*(1), 105-120. https://doi.org/10.1037/0022-0167.39.1.105

Lewandowski, K. (2019). *Predictability of supervisor characteristics and counselor anxiety on pre-licensed counselors' self-efficacy* (Publication No. 13895913) [Doctoral dissertation, Capella University]. ProQuest Dissertations & Theses Global.

Lief, H. I., and Reed, D. M. (1972). *Sex Knowledge and Attitudes Test.* University of Pennsylvania.

LoFrisco, B. M. (2013). *Counselor discomfort with sexual issues and supervisory role* (Publication No. 3602540) [Doctoral dissertation, University of South Florida. Tampa]. ProQuest Dissertations & Theses Global.

Lottes, I., Weinberg, M., & Weller, I. (1993). Reactions to pornography on a college campus: For or against? *Sex Roles, 29,* 69-89. https://doi.org/10.1007/BF00289997.

Mallicoat, W. D. (2014). Counselors' perception of sexuality in counseling: A pilot study. *The Practitioner Scholar: Journal of Counseling and Professional Psychology, 3*(1), 61-81.

Masters, W. H. & Johnson, V. E. (1966). *Human sexual response*. Little Brown.

Masters, W. H., & Johnson, V. E. (1970). *Human sexual inadequacy.* Little Brown.

May, R. (1950). *The meaning of anxiety.* Ronald Press.

Microsoft Corporation. (2018). *Microsoft Excel*. Retrieved from https://office.microsoft.com/excel

Miller, N. E., & Dollard, J. (1941). *Social learning and imitation.* Yale University Press.

Miller, S. A., & Byers, E. S. (2008). An exploratory examination of the sexual intervention self-efficacy of clinical psychology graduate students. *Training and Education in Professional Psychology*, *2*(3), 137-144. https://doi.org/10.1037/1931- 3918.2.3.137

Miller, S., & Byers, E. (2009). Psychologists' continuing education and training in sexuality. *Journal of Sex & Marital Therapy*, *35*(3), 206-219. https://doi.org/10.1080/00926230802716336

Miller, S. A., & Byers, E. S. (2012). Practicing psychologists' sexual intervention self-efficacy and willingness to treat sexual issues. *Archives of Sexual Behavior, 41*(4), 1041–1050. https://doi.org/10.1007/s10508-011-9877-3

Miller, W. R., & Lief, H. I. (1979). The sex knowledge and attitude test (SKAT). *Journal of Sex & Marital Therapy*, *5*(3), 282–287. https://doi.org/10.1080/00926237908403733

Moore, B. J. (2018). *Therapists' attitudes, knowledge, comfort, and willingness to discuss sexual topics with clients* (Publication No. 10827779) [Doctoral dissertation, Walden University]. ProQuest Dissertations & Theses Global.

Mowrer, O. H. (1950). *Learning theory and personality dynamics: selected papers.* Ronald Press.

Ng, J. S. C. (2006). *Sexuality and psychotherapy: An exploratory study of the subjectivities of psychotherapists with experience and expertise in working with sexuality* (Publication No. 3233702) [Doctoral dissertation, Rutgers The State University of New Jersey]. ProQuest Dissertations & Theses Global.

Pan American Health Organization and World Health Organization. (2001). *Promotion of sexual health: Recommendations for action.* Retrieved from: http://www.sexarchive.info/GESUND/ARCHIV/PSH.HTM

Reissing, E. D., & Giulio, G. D. (2010). Practicing clinical psychologists' provision of sexual health care services. *Professional Psychology: Research and Practice*, *41*(1), 57–63. https://doi.org/10.1037/a0017023

Russell, E. B. (2012). Sexual health attitudes, knowledge, and clinical behaviors implications for counseling. *The Family Journal, 20*(1), 94–101. https://doi.org/10.1177/1066480711430196

Skinner, B. F. (1948). 'Superstition' in the pigeon. *Journal of Experimental Psychology, 38*(2), 168–172. https://doi.org/10.1037/h0055873

Southern, S., & Cade, R. (2011). Sexuality counseling: A professional specialization comes of age. *The Family Journal*, *19*(3), 246–262. https://doi.org/10.1177/1066480711408028

Sousa, R. (2018). *Counseling supervisor self-efficacy and theoretical orientation as predictors of comfort with sexuality* (Publication No. 10745405) [Doctoral dissertation, Capella University]. ProQuest Dissertations & Theses Global.

Spielberger, C.D. (1966). Theory and research on anxiety. In C.D. Spielberger (Ed.), *Anxiety and behavior*. Academic Press.

Spielberger, C.D. (1972). Anxiety as an emotional state. In C.D. Spielberger (Ed.), *Anxiety: Current trends in theory and research (Vol. 1).* Academic Press.

Spielberger, C.D. (1983). *State-trait anxiety inventory: A comprehensive bibliography*. Consulting Psychologists Press.

Spielberger, C.D. (1989). *State-trait anxiety inventory: A comprehensive bibliography*. (2nd ed.). Consulting Psychologists Press.

Spielberger, C.D. (1983-2020). *State-Trait Anxiety Inventory (STAI) for Adults™ Manual*. Mind Garden.

Sullivan, H. S. *The interpersonal theory of psychiatry*. Norton.

Træen, B., & Schaller, S. (2013). Talking to patients about sexual issues: Experiences of Norwegian psychologists. *Sexual & Relationship Therapy*, *28*(3), 281.

https://doi.org/10.1080/14681994.2013.768338

Walenz, K. (2011). *Comparing sexual intervention self-efficacy in CACREP and non-CACREP graduates* (Publication No. 1502058) [Master's thesis, University of Nebraska]. ProQuest Dissertations & Theses Global.

Wilson, M. R. (2017). *"That's a big thing to miss": A narrative inquiry of how counselors experience client sexuality* (Publication No. AAI10272144) [Doctoral dissertation, University of Wyoming]. ProQuest Dissertations & Theses Global.

Wilson, M. R. (2019). Too taboo?: Preliminary explorations of counselor experiences of client sexuality. *Journal of Counseling Sexology & Sexual Wellness: Research, Practice, and Education*, *1*(1), 60–68. https://doi.org/10.34296/01011010

World Health Organization. (2020). *Sexual health*. Retrieved from: https://www.who.int/health-topics/sexual-health

Yulis, S., & Kieser, D. J. (1968). Countertransference response as a function of therapist anxiety and content of patient talk. *Journal of Consulting and Clinical Psychology, 32*(4), 413–419. https://doi.org/10.1037/h0026107

Zamboni, B. D., & Zaid, S. J. (2017). Human sexuality education in marriage and family therapy graduate programs. *Journal of Marital and Family Therapy, 43*(4), 605–616. https://doi.org/10.1111/jmft.12214

Table 1

Summaries of Demographic Information

Characteristics	*N*	*M*	Median	*SD*	%
Age	64	43.80	41.50	11.950	**
Gender Identity					
Male/Man/Masculine	9				13.8
Female/Woman/Feminine	52				80.0
Missing Response	4				6.2
Participant Professional License Type					
LPCC	33				50.8
LMFT	30				46.2
Dual Licensure LMFT/LPCC	2				3.1
Racial Identity					
Asian or Asian American	2				3.1
Black or African American	1				1.5
White/Caucasian/European American	59				90.8
Multiracial/Biracial	1				1.5
Other Race/Ethnicity/Origin	1				1.5
Missing response	1				1.5
Religion/Spiritual Practice/Existential Worldview Identity					
Agnostic	7				10.8
Atheist	4				6.2
Christian	32				49.2
Jewish	3				4.6
Secular/Humanist	1				1.5
Unitarian Universalist	1				1.5
Spiritual	6				6
No Religion	3				4.6
Other Non-Specified Belief	1				1.5
Missing response or ‘prefer not to answer’	7				10.8
Sexual Orientation					
Heterosexual/Straight	53				81.5
Gay or Lesbian	5				7.7
Bisexual	3				4.6
Pansexual	3				4.6
Missing response or ‘prefer not to answer’	1				1.5

Characteristics	*N*	*M*	Median	*SD*	%
Years in Professional Practice	63	10.32	8	9.060	**
Educational Level					
Master's Degree	59				90.8
Doctorate Degree	1				1.5
Both Master's and Doctorate Degree	1				1.5
Enrolled in Doctoral Program	1				1.5
Master's Degree and Enrolled in Doctoral Program	2				3.1
Master's Degree and Enrolled in Master's Program	1				1.5
Human Sexuality Training					
Undergraduate Course	8				12.3
Required Graduate Course	28				43.1
Elective in Graduate Program	3				4.6
Elective Outside Graduate Program	1				1.5
Component of Another Course	5				7.7
Continuing Education Activity	5				7.7
Self-Learning Activity (Book)	4				6.2
No Human Sexuality Training	11				16.9

Note. (*N*=65).

Table 2

Descriptive Statistics and Reliability Estimates of Scales

Scale	*N*	*M*	*SD*	Minimum	Maximum	Cronbach's α
SISEQ	65	79.06	7.888	53	94	.604
STAI S-Anxiety Scale	65	30.78	7.805	20	51	.909
STAI T-Anxiety Scale	65	32.72	8.011	20	53	.912
SDCS	65	38.37	10.484	9	57	.845

Table 3

Correlation Matrix: Sexual Intervention Self-Efficacy, State Anxiety, and Trait Anxiety

Variables	1	2	3
1. SISEQ	1	-.394**	-.303*
2. STAI S-Anxiety Scale		1	.749**
3. STAI T-Anxiety Scale			1

Note. *$p < .05$, two-tailed, **$p < .01$, two-tailed.

Table 4

Summary of Simple Multiple Regression Analyses for Variables Predicting Willingness to Discuss Sexuality with Clients (N=65)

	Coefficients[a]				
	Unstandardized Coefficients		Standardized Coefficients		
Model	*B*	*SE*	β	*t*	*p*
1 (Constant)	-13.667	16.625		-.822	.414
Sexual Intervention Self-Efficacy[b]	.534	.172	.402	3.112	.003**
State Anxiety[b]	.280	.249	.209	1.125	.265
Trait Anxiety[b]	.036	.234	.028	.155	.877

Note. $F(3, 61) = 3.354$, $p = .025$, R Squared (R^2) = .142, Adjusted R^2 = .099, Durbin-Watson = 1.730. *$p < .10$, **$p < .05$.

[a]Dependent Variable: Willingness to discuss sexuality with client (SDCS Total Score).

[b]Predictor Variables: Sexual Intervention Self-Efficacy (SISEQ Total Score), State Anxiety (STAI S-Anxiety Scale), and Trait Anxiety (STAI T-Anxiety Scale).

APPENDIX A: INTRODUCTORY LETTER

Dear Participant,

My name is Becca Thompson, MS, LMFT, and I am a counselor education and supervision doctoral candidate currently working on my dissertation project under the direction of Dr. Diane Coursol, PhD at Minnesota State University, Mankato. I would like to invite you to participate inmy research study by completing an anonymous online survey, that focuses on identifying factors that may contribute to a mental health counseling professionals' willingness to discuss sexuality issues with clients.

You may participate if you are:

1. 18 years or older.
2. A licensed professional to practice independently in the state of Minnesota that includes licensure in marriage and family therapy (LMFT) or clinical counseling (LPCC).

If you decide to participate in this research, you can enter the survey link or scan the QR code provided below to review your informed consent, and then complete the online survey. The online survey will take approximately 10-20 minutes of your time. The online survey will consistof four questionnaires that will ask you to respond to prompts or questions that assess demographic information, experiences and beliefs regarding working with clients presenting with sexuality concerns (Sexuality Discussions with Clients Scale and Sexual Intervention Self- Efficacy Questionnaire), and anxiety states and tendencies (State-Trait Anxiety Inventory). You will not be compensated.

How to Participate:

If you are interested in participating in this research, please either copy and enter the followinglink into your web browser to give your consent to complete the survey or scan the QR code using your mobile device to give your consent to complete the survey.

Survey Link: https://mnsu.co1.qualtrics.com/jfe/form/SV_24x4YYjAHWnQxxQ

QR Code:

Your participation is greatly appreciated. If you have any questions or concerns, please contact:Becca Thompson, MS, LMFT at becca.thompson.2@mnsu.edu or
Dr. Diane Coursol, PhD at diane.coursol@mnsu.edu

Kind Regards,
Becca Thompson, MS, LMFT

B. Thompson, MS, LMFT

Doctoral Candidate, Department of Counseling and Student Personnel
Minnesota State University, Mankato

APPENDIX B: INFORMED CONSENT

You are invited to participate in an online survey for research. This research is being conducted by Becca Thompson, MS under the supervision of Dr. Diane Coursol, PhD from the Department of Counseling and Student Personnel at Minnesota State University, Mankato. The purpose of this online research survey is to examine mental health counseling professionals' (MHCP) self-efficacy and anxiety as it contributes to willingness to engage is sexuality discussions with clients they counsel. Your participation in the study will contribute to a better understanding of factors that influence a MHCP's engagement in sexuality discussions with clients. If you have any questions about this research study, contact Dr. Diane Coursol at 507-389-5656 and diane.coursol@mnsu.edu.

The online survey will take approximately 10-20 minutes of your time. The online survey will consist of four questionnaires that will ask you to respond to prompts or questions that assess demographic information, experiences and beliefs regarding working with clients presenting with sexuality concerns (Sexuality Discussions with Clients Scale and Sexual Intervention Self-Efficacy Questionnaire), and anxiety states and tendencies (State-Trait Anxiety Inventory). You will not be compensated.

Your decision to participate or decline participation in this study is voluntary. You may decline to answer any question and you have the right to withdraw from participation at any time by closing out of the web browser. The decision whether or not to participate will not affect your relationship with Minnesota State University in anyway and refusal to participate will involve no penalty or loss of benefits.

Responses will be anonymous. However, whenever one works with online technology there is always the risk of compromising privacy, confidentiality, and/or anonymity. If you would like more information about the specific privacy and anonymity risks posed by online surveys, please contact the Minnesota State University, Mankato IT Solutions Center (507-389-6654) and ask to speak to the Information Security Manager.

The content in some of the questionnaires contains sexually explicit material that may provoke personal discomfort or distress to you as a participant. The sexually based content is intended to assess your professional experience in the counseling setting. However, personal history, beliefs, values, and attitudes may be triggered by the items asked on the survey. This may pose a risk to you by evoking emotional, cognitive, or physiological arousal, which you may feel uncomfortable, distressed, sad, or tired. Should this occur and you need immediate assistance, please dial from your phone 2-1-1 for United Way 2-1-1 (formerly First Call for Help) which is a free and confidential service for providing you with local resources that you may need 24 hours a day.

There will be no monetary costs to participating in this survey. Your participation in this research may not benefit you personally. Society might benefit by the increased understanding of factors that contribute to mental health counseling professionals' effectiveness.

If you have any questions about participants' rights and for research-related injuries, please contact the Administrator of the Institutional Review Board, at (507) 389-1242.

Minnesota State University, Mankato IRBNet Id# 1702450
Date of Minnesota State University, Mankato IRB approval: 2/18/21

By responding "Yes" below to "Do you consent?" indicates your informed consent to participate and indicate your assurance that you are at least 18 years of age. Please print a copy of this page for your future reference. If you cannot print the consent form, take a screen shot, paste it to a word document and print that.

APPENDIX C: DEMOGRAPHIC QUESTIONNAIRE

1. How do you currently describe your gender identity?
    - _____
    - I prefer not to answer

2. Age?
    - _____
    - I prefer not to answer

3. What categories describe you? Select all that apply to you:
    - American Indian or Alaska Native – For example, Navajo Nation, Blackfeet Tribe, Mayan, Aztec, Native Village of Barrow Inupiat Tradition Government, Nome Eskimo Community
    - Asian – For example, Chinese, Fillipino, Asian Indian, Vietnamese, Korean, Japanese
    - Black or African American – For example, Jamaican, Haitian, Nigerian, Ethiopian, Somalian
    - Hispanic, Latino or Spanish Origin – For example, Mexican or Mexican American, Puerto Rican, Cuban, Salvadoran, Dominican, Columbian
    - Middle Eastern or North African – For example, Lebanese, Iranian, Egyptian, Syrian, Moroccan, Algerian
    - Native Hawaiian or Other Pacific Islander – For example, Native Hawaiian, Samoan, Chamorro, Tongan, Fijian, Marshallese
    - White – For example, German, Irish, English, Italian, Polish, French
    - Some other race, ethnicity, or origin, please specify: _____
    - I prefer not to answer.

4. How would you describe your religion, spiritual practice, or existential worldview?
    - Please specify: _____
    - I prefer not to answer.

5. Do you consider yourself to be:
    - Heterosexual or straight
    - Gay or lesbian
    - Bisexual
    - Fluid
    - Pansexual
    - Queer
    - Demisexual
    - Questioning
    - Asexual
    - I prefer not to answer.

6. Which license to practice professional counseling do you hold?
    - Licensed Marriage and Family Therapy (LMFT)
    - Licensed Professional Clinical Counselor (LPCC)

7. Which of the following categories describes the practice you primarily work?
    - Correctional Facility
    - University Counseling Center
    - Outpatient Agency
    - Inpatient Facility
    - Private Practice
    - Other:_____

8. How many years have you been providing professional counseling as a licensed mental health professional?
    - _____

9. Which educational category describes you best? Select all that apply to you:
    - Master's degree (MS, MA, MFA, MSW, MEd, MBA)
    - Enrolled in a Master's degree seeking program
    - Doctorate degree (MD, EdD, PhD, DTh, PsyD)
    - Enrolled in a doctorate degree seeking program
    - Other, please specify: _____

10. What category best describes your human sexuality education?
    - Completed a human sexuality course in my undergraduate program. Please specify the topic/title of the course _____
    - Required to complete a human sexuality course in my graduate program. Please specify the topic/title of the course _____
    - Completed a human sexuality course as an elective that was provided by my graduate program. Please specify the topic/title of the course _____
    - Completed a human sexuality course as an elective that was provided by a program outside my graduate program. Please specify the topic/title of the course _____
    - Human sexuality training and education was provided as a component of another course that was not specific to human sexuality. Please specify the course _____
    - Engaged in self-directed human sexuality training and education through participation in a continuing education activity (workshop, conference, seminar, etc.) that focused on human sexuality and was more than six hours. Please specify the topic/title of the continuing education activity _____
    - Engaged in self-directed human sexuality training and education through reading a nonfiction, informational book about human sexuality. Please list the topic/title of the book _____
    - Completed another form of human sexuality training and education that was not listed. Please describe the activity that you engaged: _____
    - I have not completed any human sexuality training and education

APPENDIX D: SEXUAL INTERVENTION SELF-EFFICACY QUESTIONNAIRE

Wednesday, November 4, 2020 at 10:12:39 Central Standard Time

Subject: Re: Research Instrumentation Request
Date: Monday, November 2, 2020 at 6:06:48 AM Central Standard Time
From: Sandra Byers
To: Thompson, Becca L
Attachments: Sexual Intervention Self-Efficacy Scale with Scoring Instructions.docx

Becca—

Your proposed research sounds very interesting. By all means use our scale. I have attached a copy in case that's useful to you.

E. Sandra Byers
Professor & Chair• Department of Psychology
Fellow, Royal Society of Canada
T 506-458-7803
https://www.unb.ca/faculty-staff/directory/arts-fr-psychology/byers-sandra.html

From: "Thompson, Becca L" <becca.thompson.2@mnsu.edu>
Date: Tuesday, October 27, 2020 at 9:27 PM
To: Sandi Byers <byers@unb.ca>
Subject: Research Instrumentation Request

External message: Use caution.

Dear Dr. E. Sandra Byers,

My name is Becca Thompson, MS, LMFT, and I am a doctoral student in Counselor Education and Supervision at Minnesota State University, Mankato. I am working towards the approval of my dissertation research by my committee, which needs to include my instrumentation. I am proposing to

investigate the relationships of sexual intervention self-efficacy, state anxiety, and trait anxiety, and the influence that these independent variables have on a mental health counseling professional's willingness to discuss sexual issues with clients.

I am a practicing licensed marriage and family therapy at a community-based agency and in my work with individuals and couples, have particular interest in how the topic of sexuality is experienced in the counseling setting. In my doctoral research, I have been able to meld these experiences with my focus by exploring factors that predict a mental health counseling professional's comfort and willingness with sexuality discussions.

In review of the literature, and I am sure as you know, I had found that self-efficacy greatly impacts counselor skill and performance. This led me to discovering the construct of sexual intervention self-efficacy in your study (Miller & Byers, 2008), which I desire to build more empirical evidence in the impact that this variable has on a counselor's willingness to discuss sexual topics with client. Despite the connection that you and other researchers have addressed to between self-efficacy and anxiety, there has not been any research to date that has investigated the relationship of state and trait anxiety (as measured by the STAI) with willingness to discuss sexual issues with clients. I also very much took the suggestions in your study (Miller & Byers, 2008) that "the development of sexual intervention self-efficacy may be more strongly affected by general anxiety than by sexual anxiety" (p. 142) and "Future research should assess anxiety related to discussing a client's sexual experiences" (p. 142) seriously, which is what I plan to explore in my dissertation research.

I would like to explore the independent variable of sexual intervention self-efficacy among mental health counseling professionals and would like to ask for your permission in utilizing your *Sexual Intervention Self-Efficacy Questionnaire* to measure this construct. I will be creating a digital survey using Qualtrics to administer the instrument, so your permission to reproduce digitally, would be greatly appreciated. I would also like to request any manual or instruction for scoring and interpretation.

I am fascinated by your work and I respect the expertise you have in human sexuality. I would appreciate any suggestions or feedback you have regarding my dissertation. Thank you for your time and consideration. You can contact me at your earliest convenience at (507)-779-4807 or by email at: becca.thompson.2@mnsu.edu.

Thank you so much,
Becca

Becca Thompson, MS, LMFT
Doctoral Candidate

Sexual Intervention Self-Efficacy Questionnaire

(Miller & Byers, 2008)

The following questionnaire asks about your thoughts and feelings concerning your CURRENT ability to work with individuals who have sexual concerns/problems. Please indicate the degree to which you agree/disagree with each statement on the following scale:

1. I have very little knowledge of the interventions used to treat sexual problems

Strongly Disagree	**Disagree**	**Slightly Disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**
6	5	4	3	2	1

2. There are issues related to sexuality that I would not feel comfortable talking to a client about

Strongly Disagree	**Disagree**	**Slightly Disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**
6	5	4	3	2	1

3. I am unfamiliar with the techniques used to intervene with individuals who have sexual concerns/problems

Strongly Disagree	**Disagree**	**Slightly Disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**
6	5	4	3	2	1

4. If a couple told me that they were having a sexual problem I would refer them to another clinician.

Strongly Disagree	**Disagree**	**Slightly Disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**
6	5	4	3	2	1

5. I am fairly certain that my own biases will not hinder my ability to effectively treat individuals who have sexual concerns/problems.

Strongly Disagree	**Disagree**	**Slightly Disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**
1	**2**	**3**	**4**	**5**	**6**

6. I know some techniques that can help couples who are having sexual problems.

Strongly Disagree	**Disagree**	**Slightly Disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**
1	**2**	**3**	**4**	**5**	**6**

7. I am able to teach clients specific skills to deal with their sexual concerns/problems

Strongly Disagree	**Disagree**	**Slightly Disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**
1	**2**	**3**	**4**	**5**	**6**

8. I think that it would be best to refer a client if they had a sexual concern/problem.

Strongly Disagree	**Disagree**	**Slightly Disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**
6	5	4	3	2	1

9. I will be able to treat clients with sexual problems even when I don't necessarily agree with their decisions/actions

Strongly Disagree	**Disagree**	**Slightly Disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**
1	**2**	**3**	**4**	**5**	**6**

10. Sexual dysfunction is something that I do not know how to treat

Strongly Disagree	**Disagree**	**Slightly Disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**
6	5	4	3	2	1

11. I worry that I would seem uncomfortable if a client talked to me about masturbation

Strongly Disagree	**Disagree**	**Slightly Disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**
6	5	4	3	2	1

12. I would probably do more harm than good if I tried to work with an individual who had a sexual concern/problem.

Strongly Disagree	**Disagree**	**Slightly Disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**
6	5	4	3	2	1

13. I am confident that I can relay accurate information to clients about:

a) Sexual orientation/identity issues

Strongly Disagree	**Disagree**	**Slightly Disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**
1	2	3	4	5	6

b) Sexual violence

Strongly Disagree	**Disagree**	**Slightly Disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**
1	2	3	4	5	6

c) Sexual dysfunction and problems

Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1	2	3	4	5	6

d) STI/STDs

Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1	2	3	4	5	6

e) Conflict over sexual issues in relationships (e.g. differing sex drive)

Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1	2	3	4	5	6

f) Sexual issues in aging

Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1	2	3	4	5	6

g) Childhood/adolescent sexual development

Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1	2	3	4	5	6

Reverse the scoring on Items 1, 2, 3, 8, 9, 11
Comfort/Bias Self-Efficacy (items 2, 4, 7, 9, 11)
Skill Self-Efficacy (Items 1, 3, 5, 6, 8, 10, 12)
Information Self-Efficacy (Items 13a to 13g)

APPENDIX E: SEXUALITY DISCUSSIONS WITH CLIENTS SCALE

Wednesday, October 28, 2020 at 11:10:04 Central Daylight Time

Subject: Re: Research Instrument Request
Date: Wednesday, October 28, 2020 at 8:48:12 AM Central Daylight Time
From: Steven Harris
To: Thompson, Becca L

Becca,

Great to hear from you and of your research interests. Feel free to use the instrument from our 2008 study, just give us credit. Kelli Hays also has a dissertation with a similar title out there that you can probably order on inter library loan. It will have all the instruments we used and how to score them. It has been forever since I was involved in that project but that project has inspired a lot of research in a variety of disciplines. You should have a solid lit review section you can put together.

I'm happy to talk further if you'd like, but like I said, it has been a while since I've been in that literature. You're probably more of an expert on the topic than I am. :)

Wishing you the best with your research and much success in your career.

Steve

On Tue, Oct 27, 2020 at 6:25 PM Thompson, Becca L <becca.thompson.2@mnsu.edu> wrote:

> Dear Dr. Steven M. Harris,
>
> My name is Becca Thompson, MS, LMFT, and I am a doctoral student in Counselor Education and Supervision at Minnesota State University, Mankato. I am working towards the approval of my dissertation research by my committee, which needs to include my instrumentation. I am proposing to investigate the relationships of sexual intervention self-efficacy, state anxiety, and trait anxiety, and the influence that these independent variables have on a mental health counseling professional's willingness to discuss sexual issues with clients.
>
> I am a practicing licensed marriage and family therapy at a community-based agency and in my work with individuals and couples, have particular interest in how the topic of sexuality is experienced in the counseling setting. In my doctoral research, I have been able to meld these experiences in with my focus by exploring mental health counseling professional's comfort and willingness with sexuality discussions for approximately seven years, inspired by your work (Harris & Hays, 2008) with this topic. The literature continues to address the need of mental health counseling professionals to examine and develop their sense of sexual comfort through their educational opportunities, which still lacks among counselor education.
>
> In my review of the literature, I find that self-efficacy has a great impact of counselor skill and performance. This led me to discovering the construct of sexual intervention self-efficacy, desiring to build more evidence of the impact that this variable has on a counselor's willingness to discuss sexual topics with clients, further informing counselor education and training. Predictors of self-efficacy have included education and training, supervision, and anxiety, similar to the work you and Dr. Hays (2008) had done. Despite the connection that you and other researchers have alluded to between comfort and anxiety, there has not been any research to date that has investigated the relationship of state and trait anxiety (as measured by the STAI) with willingness to discuss sexual issues with clients.

I would like to explore the dependent variable of comfort and willingness to have sexuality discussions with clients and would like to ask for your permission in utilizing your *Sexuality Discussions with Clients Scale* to measure this construct. I have found that your instrument has the construct validity I am seeking for this research. I will be creating a digital survey using Qualtrics to administer the instrument, so your permission to reproduce digitally, would be greatly appreciated. I would also like to request any manual or instruction for scoring and interpretation.

As stated earlier, your research in 2008 has been a hallmark for igniting my interest in this area, and I greatly respect your work. I would appreciate any suggestions or feedback you have regarding my dissertation. Thank you for your time and consideration. You can contact me at your earliest convenience at (507)-779-4807 or by email at: becca.thompson.2@mnsu.edu.

Thank you so much,

Becca

--

Steven M. Harris, Ph.D., LMFT
Professor
Couple and Family Therapy
Dept. Family Social Science

University of Minnesota
290 McNeal Hall
St. Paul, MN 55108
(612) 625-3735

Editor in Chief
Journal of Marital and Family Therapy

Associate Project Director
Minnesota Couples on the Brink Project
www.mncouplesonthebrink.org

Product Details

Sexuality Discussions with Clients 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:

	Never			**Sometimes**			**Very Often**
Sexuality transmitted disease/infections	1	2	3	4	5	6	7
Sexual dysfunction	1	2	3	4	5	6	7
Client satisfaction with their sexual life	1	2	3	4	5	6	7
Client's typical sexual interaction pattern	1	2	3	4	5	6	7
Reproduction and/or contraception	1	2	3	4	5	6	7
Sexual orientation	1	2	3	4	5	6	7
Sexual relationship enhancement	1	2	3	4	5	6	7
Sex abuse	1	2	3	4	5	6	7

	Strongly Agree						**Strongly Disagree**
I only assess and initiate conversations on sexuality related issues when the client states that it is a concern	1	2	3	4	5	6	7

Harris, S. M., & Hays, K. W. (2008). Family therapist comfort with and willingness to discuss client sexuality. *Journal of Marital and Family Therapy*, *34*(2), 239–250. https://doi.org/10.1111/j.1752-0606.2008.00066.x

Hays, K. W. (2002). *The influence of sexuality education and supervision, clinical experience, perceived sex knowledge, and comfort with sexual content on therapists addressing sexuality issues with clients* (Publication No. 3069179) [Doctoral dissertation, Texas Tech University, Lubbock]. ProQuest Dissertations & Theses Global.

APPENDIX F: PERMISSION TO USE STATE-TRAIT ANXIETY INVENTORY

mind garden

www.mindgarden.com

To Whom It May Concern,

The above-named person has made a license purchase from Mind Garden, Inc. and has permission to administer the following copyrighted instrument up to that quantity purchased:

State-Trait Anxiety Inventory for Adults

The four sample items only from this instrument as specified below may be included in your thesis or dissertation. Any other use must receive prior written permission from Mind Garden. The entire instrument may not be included or reproduced at any time in any other published material. Please understand that disclosing more than we have authorized will compromise the integrity and value of the test.

Citation of the instrument must include the applicable copyright statement listed below.
Sample Items:

I feel at ease
I feel upset
I lack self-confidence
I am a steady person

Sincerely,

Robert Most
Mind Garden, Inc.
www.mindgarden.com