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Assessing Help-Seeking Attitudes, Service Utilization, and Provider Preferences Among Undergraduate Students With Self-Reported Sexual Functioning Concerns

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Abstract

Researchers who have studied help-seeking for sexual concerns have consistently documented that individuals, couples, and families underutilize services. Additionally, research has demonstrated that individuals endorse myriad barriers to seeking informal and formal help, especially for sexual functioning concerns. This study examined the types of sexual concerns faced by a sample of 347 of undergraduate students, their provider preferences in the past, present, and future, and their help-seeking behaviors for formal and informal help sources. Despite the occurrence of sexual functioning concerns in the current study, services that address sexual concerns were largely underutilized. However, barriers to seeking help and negative attitudes toward seeking help did not seem to be primary reasons for the underutilization of services for the current sample. Results also indicated that providers that focus specifically on the treatment of sexual functioning concerns are among the most underutilized services.

Keywords: sexual functioning concerns, undergraduates, provider preferences, help-seeking

CHAPTER 1: INTRODUCTION

Assessing Help-Seeking Attitudes, Service Utilization, and Provider Preferences Among Undergraduate Students With Self-Reported Sexual Functioning Concerns

Underutilization of mental health services has been consistently documented in the literature on help-seeking. Individuals, couples, and families are often reluctant to seek help from mental health professionals for a variety of problems including concerns related to sexual functioning (Cohen, 2006; Gulliver, Griffiths, & Christensen, 2010; Nicolosi, Laumann, Glasser, Brock, King, & Gingell, 2006; Papaharitou, Nakopoulou, Kirana, Iraklidou, Athanasiadis, & Hatzichristou, 2005; Shifren, Johannes, Monz, Russo, Bennett, & Rosen, 2009; Slowinski, 2007; Sobczak, 2009b). In fact, one researcher found that only 4% of the study's target sample of undergraduate students sought formal professional help for a sexual concern (Harrison, 1987).

College-aged students experience a range of sexual concerns in spite of the fact that this population is generally healthy, educated, and young, which are protective factors for sexual health (Weismeier & Forsythe, 1982). According to Cohen (2006), "inadequately informed and frightened of pathology, students may live with unspoken feelings of sexual inadequacy that corrode self-esteem, taint self-concept, and diminish their readiness to seek help for sexual concerns, sexual conflicts are usually amenable to therapeutic interventions, yet young people are often too uncomfortable to articulate these issues to themselves, let alone others" (p. 215). Thus, sexual concerns can have many negative impacts on students' personal well-being, but despite these negative impacts, students may possess fears about help-seeking that outweigh the foreseeable benefits of getting help. However, students who engage in sexual activities can alleviate stress, become closer to significant others, and gain pleasure (Metz & McCarthy, 2007). For those who choose to seek help, mental health professionals can help maximize and

emphasize the benefits of engaging in sexual activity. At the same time, mental health professionals can help minimize the costs associated with seeking help for a sexual concern and the negative impacts of problematic sexual functioning. Thus, in order to aid undergraduate students in maximizing the benefits and limiting the costs of engaging in sexual activity, an investigation of this sample's needs and practices is important.

Since the 1970s, researchers have suggested that sexual functioning concerns are prevalent in the United States, yet despite the high prevalence, few people seek help for such concerns (Babineau & Schwartz, 1977). Almost 40 years later, the literature on service utilization and sexual functioning concerns continues to support this claim (Cohen, 2006; Gulliver, Griffiths, & Christensen, 2010; Shifren, Johannes, Monz, Russo, Bennett, & Rosen, 2009; Sobczak, 2009b). Although many people still report sexual functioning concerns today, professional services to help these individuals are grossly underutilized. In order to overcome the past trend of high prevalence and underutilization, a greater understanding of the barriers to help-seeking must be investigated. It is also important to gain a greater understanding of factors that facilitate help-seeking and, more specifically, how mental health professionals contribute to facilitating counseling service utilization. Although many researchers have examined characteristics of the individual with regard to underutilization of services, fewer researchers have examined characteristics of mental health professionals in facilitating service utilization. Additionally, fewer researchers have examined provider preferences with regard to underutilization of services. A greater understanding of how mental health professionals contribute to the barriers to help-seeking for sexual functioning concerns, and an enhanced understanding of how mental health professionals can facilitate help-seeking, may lead professionals to reevaluate current methods of promoting mental health services and begin to

change the trend of underutilization. Through identifying these gaps, mental health professionals can work toward accessing previously restricted populations.

The current study investigated help-seeking behaviors and service utilization in a sample of undergraduate students with sexual functioning concerns at a large state university. The purpose of the investigation was to assess the occurrence of sexual functioning concerns in a sample of young people and gain a comprehensive understanding of this sample's help-seeking attitudes, service utilization behaviors, provider preferences, and perceived barriers to seeking professional help. The researcher evaluated attitudes toward help-seeking, as well as previous, current, and potential future help-seeking behaviors. Additionally, the researcher evaluated the type of help sought in the past, present, and potential future from a range of informal and formal sources. Furthermore, participants were asked to identify past, present, and future provider preferences among mental health professionals.

The purposes of the current study are threefold: (1) to evaluate the occurrence of sexual functioning concerns in a sample of undergraduate students and identify the sample's most common concerns; (2) to assess attitudes toward seeking professional help, perceived barriers to seeking professional help, as well as past, present, and future utilization of formal and informal help sources for sexual functioning concerns; and (3) to identify provider preferences among mental health professionals in order to identify potential barriers for underutilized mental health fields.

CHAPTER 2: LITERATURE REVIEW

Current research suggests that sexual functioning concerns can cause serious distress for individuals, couples, and families (Basson, 2001; McCarthy & Metz, 2008, Shifren, Johannes, Monz, Russo, Bennett, & Rosen, 2009), which is often combined with the underutilization of mental health and medical services to address these concerns (Cohen, 2006; Gulliver, Griffiths, & Christensen, 2010; Nicolosi, Laumann, Glasser, Brock, King, & Gingell, 2006; Papaharitou, Nakopoulou, Kirana, Iraklidou, Athanasiadis, & Hatzichristou, 2005; Slowinski, 2007; Sobczak, 2009b). Given the level of distress incurred by individuals experiencing sexual functioning concerns, many researchers consider sexual functioning concerns an important public health issue (Butler, O'Donovan, & Shaw, 2010; Laumann, Paik, & Rosen, 1999; Slowinski, 2007; Zakhari, 2009). Through a deeper understanding of the presenting sexual concerns and subsequent utilization of mental health and medical services in a sample of undergraduate students, the current study helps identify gaps to inform clinicians of areas to increase accessibility and decrease barriers.

In the literature, problematic sexual functioning has been referred to as sexual dysfunction. For the purposes of the current study and the sample investigated, the language of sexual dysfunction may be too extreme as it refers to a specific type of sexual concern, those diagnosable due to the level of impairment. For that reason, any problem or concern an undergraduate student has with regard to his or her sexual functioning is referred to in this manuscript as a sexual functioning concern. Sexual functioning concerns are defined as any concern an undergraduate student expresses in regard to satisfaction, orgasm, pain, arousal, and/or desire. A student may express sexual concerns due to a change in his or her sexual behavior, a new experience, or questioning what is normal (Butler, O'Donovan, & Shaw, 2010;

Cohen, 2006). In fact, in the early stages of sexual development, it is common for individuals to be uncertain about what constitutes a normal sexual experience, which can cause distress until the individual develops sexual awareness and negotiates his or her preferred types of sexual behavior (Butler, O'Donovan, & Shaw, 2010). The current definition of sexual functioning concerns is purposefully vague in order to allow space for a range of experiences related sexual functioning concerns. What is important, and less prevalent in the literature on sexual functioning concerns, is to investigate a range of individuals' subjective experiences and understand sexual experiences as embedded in a biopsychosocial framework.

Given the complex nature and high prevalence of sexual functioning concerns and sexual dysfunction, it is no wonder that resources to alleviate sexual functioning distress are underutilized. Based on a multitude of causes and effects, individuals may be hesitant to seek help for any number of reasons. However, due to the high prevalence of sexual functioning concerns and complex etiology, low instances of help seeking behaviors are both a quality of life issue and a public health concern. Consequences of not seeking help for a sexual functioning concern or sexual dysfunction include biopsychosocial costs to the individual and his or her partner(s). Additionally, there are consequences at the macro level, which include high divorce rates, families with a single parent, and domestic violence (West, Vinikoor, & Zolnoun, 2004). Researchers must better understand the specific consequences of continuing to ignore this important social and individual issue. Specifically, mental health professionals must be aware of this as a pervasive issue facing many people, which causes mental distress. Researchers since the 1970s have consistently found that people often do not seek help for sexual issues in spite of the high prevalence and the serious personal and interpersonal consequences of such issues

(Babineau & Schwartz, 1977). Identifying how mental health professionals are underutilized allows mental health professionals to take action to alleviate the gap in services.

In order to understand how help-seeking behaviors and sexual functioning concerns have come together from distinctive backgrounds, it is important to examine each divergent body of literature on its own. This is useful to gain a comprehensive understanding of the current trends in each field, which will help the reader better understand how they fit together.

Sexual dysfunction

Although the current study refers to problematic sexual functioning as sexual functioning concerns, the literature on this topic traditionally refers to problematic sexual functioning as sexual dysfunction. Additionally, both mental health and medical professionals classify sexual dysfunctions as disorders, which have been defined in the Diagnostic and Statistic Manual of Mental Disorders (DSM). The most current version of the DSM (DSM-IV-TR) provides definitions of sexual dysfunctions and disorders in four specific categories: desire disorders, arousal disorders, orgasmic disorders, and sexual pain disorders. A person presenting to therapy with sexual functioning concerns may be diagnosed with a sexual disorder if he or she meets the DSM-IV-TR diagnostic criteria for a sexual disorder and his or her symptoms are not better accounted for by any other diagnosis in the DSM-IV-TR. While the current study uses the language of sexual functioning concerns, throughout this section, the language sexual dysfunction is used to reflect what is commonly used in the body of literature.

Background. Given that the quality of and satisfaction with one's sexual life is a predictor of overall quality of life (Metz & McCarthy, 2007; Symonds, Boolell, & Quirk, 2005; Zakhari, 2009), it seems that sexual functioning concerns are a salient contributor to mental distress. Medical professionals as well as mental health professionals often neglect sexual

functioning concerns during routine visits despite its effects on quality of life (Fitter, Hayter, & Wylie, 2009; Shifren, Johannes, Monz, Russo, Bennett, Rosen, 2009; Sobczak, 2009b). The literature on sexual functioning concerns suggest that they are common and that this high prevalence is often coupled with resistance and reluctance to seek professional help (Cohen, 2006; Nicolosi, Laumann, Glasser, Brock, King, & Gingell, 2006; Papaharitou, Nakopoulou, Kirana, Iraklidou, Athanasiadis, & Hatzichristou, 2005; Shifren, Johannes, Monz, Russo, Bennett, & Rosen, 2009; Slowinski, 2007; Sobczak, 2009b).

Additionally, sexual dysfunctions have a complex etiology and often have a high rate of comorbidity with other mental health concerns and medical conditions. They are also often considered a relational problem because sexual dysfunctions are usually not isolated with the individual (Leiblum, 2007; Woody, 1992). However, not all sexual dysfunctions or sexual functioning concerns affect all people in the same way. It is possible that sexual dysfunction causes a range of experiences within an individual and his or her partner(s). One person and his or her partner(s) may experience sexual dysfunction and experience high distress, while another person and his or her partner(s) may experience sexual dysfunction and experience no distress or consequences in his or her interpersonal relationship(s) (Leiblum, 2007). Thus, there is no formula for understanding sexual dysfunction due to the incredible diversity of experience related to etiology, type of complaint, and effect of the complaint.

Currently, the language that exists for discussing sexual functioning concerns is often pathologizing. Terms such as dysfunction and disorder tend to be used when describing an individual experiencing problematic sexual functioning. Recently, researchers have moved toward adopting less pathologizing language for premature ejaculation and erectile dysfunction, however these terms are still widely accepted and utilized in the literature. For purposes of the

current paper, sexual functioning concerns is the language most commonly used to refer to problematic sexual functioning or sexual dysfunction. For the undergraduate sample whose sexual problems may not be severe enough to diagnose a sexual dysfunction, sexual functioning concerns may be more appropriate language. What is important to understand is that absence of a sexual dysfunction does not necessarily mean the presence of healthy sexual functioning. This is especially true for the undergraduate sample that may be facing anxiety, stress, and confusion with regard to sexual functioning.

Definitions. Traditional definitions of sexual dysfunctions are rooted in a modernist understanding of human behaviors. However, with regard to sexuality and sexual functioning, it is important to understand individuals' experience with their own development of sexual problems and their own experience with personal distress related to these problems. There is limited overlap between one person's experience and the next person's experience. Allowing individuals to have their own story with regard to sexual problems allows each person to define the problem as they have experienced and treatment can be tailored to the individual person's distress and symptom profile. Sexual dysfunction is not static, but rather is constantly changing and evolving.

Despite the range in individuals' experiences, definitions have been established for a range of sexual problems including orgasmic problems, pain problems, arousal problems, and desire problems. These definitions are often determined based on an understanding of normal sexuality as embedded in Masters and Johnson and Kaplan's research on human sexual response. However, given the range in human sexual behavior and response, it is possible that someone who qualifies as sexually dysfunctional is only experiencing a different sexual response. Greater acceptance of a range of sexual response will lead to fewer individuals being diagnosed with a

disorder and pathologized (Leiblum, 2007). Thus, there may be a difference between how sexual dysfunction is diagnosed clinically and how it is experienced subjectively. Creating definitions based on subjective experience could greatly change our current clinical definitions based on the DSM-IV-TR.

Laumann and colleagues (1999) define sexual dysfunctions as "disturbances in sexual desire and in psychophysiological changes associated with sexual response cycle in men and women" (p. 537). Woody (1992) refers to sexual functioning concerns as sexual distress, which can be further specified as generalized or situational and lifelong or acquired. To understand sexual problems, it is also important to understand what constitutes sexual satisfaction, which Metz & McCarthy (2007) says is based on realistic sexual expectations and healthy interpersonal relationships**.** See Figure 1 for a summary of definitions and related information.

Figure 1
Summary of Definitions and Related Information for Sexual Dysfunction

	Desire Disorders		Arousal Disorders		Orgasmic Disorders		Sexual Pain Disorders	
Female	**Types**	• Hypoactive Sexual Desire Disorder • Sexual Aversion Disorder • Sexual Dysfunction Due to a General Medical Condition • Substance-Induced Sexual Dysfunction	**Types**	• Female Sexual Arousal Disorder • Sexual Dysfunction Due to a General Medical Condition • Substance-Induced Sexual Dysfunction	**Types**	• Female Orgasmic Disorder • Sexual Dysfunction Due to a General Medical Condition • Substance-Induced Sexual Dysfunction	**Types**	• Dyspareunia • Vaginismus • Sexual Dysfunction Due to a General Medical Condition • Substance-Induced Sexual Dysfunction
	Prevalence	27-32%	**Prevalence**	76%	**Prevalence**	8-63%	**Prevalence**	8-24%
	Definition	**Hypoactive Sexual Desire Disorder:** a deficiency or absence of sexual fantasies and desire for sexual activity	**Definition**	**Female Arousal Disorder:** vasocongestion in the pelvis, vaginal lubrication and expansion, and swelling of the external genitalia	**Definition**	**Female Orgasmic Disorder:** persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase	**Definition**	**Dyspareunia:** genital pain that is associated with sexual intercourse **Vaginismus:** persistent involuntary contraction of the perineal muscles surrounding the outer third of the vagina when vaginal penetration with penis, finger, tampon, or speculum is attempted

	Desire Disorders		Arousal Disorders		Orgasmic Disorders		Sexual Pain Disorders	
Male	**Types**	• Hypoactive Sexual Desire Disorder • Sexual Aversion Disorder • Sexual Dysfunction Due to a General Medical Condition Substance-Induced Sexual Dysfunction	**Types**	• Male Erectile Disorder • Sexual Dysfunction Due to a General Medical Condition Substance-Induced Sexual Dysfunction	**Types**	• Male Orgasmic Disorder • Premature Ejaculation • Sexual Dysfunction Due to a General Medical Condition Substance-Induced Sexual Dysfunction	**Types**	• Dyspareunia • Sexual Dysfunction Due to a General Medical Condition Substance-Induced Sexual Dysfunction
	Prevalence	13-17%	**Prevalence**	7-35%	**Prevalence**	5.6-77.3%	**Prevalence**	6%
	Definition	**Hypoactive Sexual Desire Disorder:** a deficiency or absence of sexual fantasies and desire for sexual activity	**Definition**	**Male Erectile Disorder:** persistent or recurrent inability to attain, or to maintain until completion of sexual activity, an adequate erection	**Definition**	**Premature Ejaculation:** persistent or recurrent onset of orgasm and ejaculation with minimal sexual stimulation before, on, or shortly after penetration and before the person wishes it. **Male Orgasmic Disorder:** persistent or recurrent delay in or absence of, orgasm following a normal sexual excitement phase	**Definition**	**Dyspareunia:** genital pain that is associated with sexual intercourse

*Definitions and types based on the DSM-IV-TR (APA, 2000a).

Male sexual dysfunction. The DSM-IV-TR identifies hypoactive sexual desire disorder, sexual aversion disorder, erectile disorder, male orgasmic disorder, premature ejaculation, and dyspareunia as potential sexual dysfunctions facing males. These six diagnoses can be specified as generalized or situational and lifelong or acquired. The DSM-IV-TR identifies that these problems may be due to psychological or a combination of psychological and biological factors. All disorders identified in the DSM-IV-TR must be causing "marked distress or interpersonal difficulty" in order to be diagnosed as a disorder (APA, 2000a).

Desire. Sexual desire often decreases in men as they age. The most comprehensive study on aging men to date is the Massachusetts Male Aging Study, which helped give a more comprehensive picture of what constitutes normal sexual desire for men as they age. This study determined that men as they age experience a consistent decline in desire for sexual activity (Leiblum, 2007). Less is known about what is considered normal and abnormal in younger men. Lack of sexual desire in men is referred to as hypoactive sexual desire disorder in the DSM-IV-TR. Hypoactive sexual desire disorder is defined as, "a deficiency or absence of sexual fantasies and desire for sexual activity" (APA, 2000a, p. 539).

Erectile dysfunction. Erectile dysfunction (ED) has been the focus of much of the research on male sexual dysfunction. ED can be caused by numerous factors and cause significant distress for the male and his partner(s). Prevalence estimates for ED are estimated as high as 35% (Laumann, Paik, & Rosen, 1999; Slowinksi, 2007). This number increases when prevalence rates are assessed in older males. According to Leiblum (2007), 50% of men over 60 experience ED although this problem causes less distress for men as they age. Persons' experience of ED exists on a continuum from problems developing after years of normal functioning to never having been able to maintain an erection sufficient for sexual activity.

Masters and Johnson refer to the latter as primary impotence, which would not be used if a man has ever been able to maintain an erection sufficient for sexual activity (Masters & Johnson, 1970). The prevalence of ED increases with age and it can be unpredictable for sufferers as it manifests in a range of situations and with varying degrees of severity (Leiblum, 2007; Slowinski, 2007). With the advent of Viagra, ED has been largely treated as a medical condition. However, the etiology of ED is just as complex as other sexual dysfunctions and can have a range of underlying causes. The DSM-IV-TR defines erectile dysfunction as the, "persistent or recurrent inability to attain, or to maintain until completion of sexual activity, an adequate erection" (APA, 2000a, p. 545).

Premature ejaculation. Premature ejaculation (PE) has caused much controversy in the literature on male sexual dysfunction. This is due to the fact that PE is difficult to define and many researchers do not agree on a single definition of this sexual problem. The subjective nature of what constitutes premature ejaculation has made proper assessments and diagnostic criteria difficult to define (McMahon, Abdo, Incrocci, Perelman, Rowland, Waldinger, & Xin, 2010). Without a proper definition, treatment for PE has also been difficult. Operational definitions have attempted to quantify PE based on the number of "intravaginal thrusts between penetration and ejaculation" (p. 59), which is still subjective and does not account for those who ejaculate prior to penetration or during anal or oral sex (McMahon, Abdo, Incrocci, Perelman, Rowland, Waldinger, & Xin, 2010). The DSM-IV-TR defines PE as the "persistent or recurrent onset of orgasm and ejaculation with minimal sexual stimulation before, on, or shortly after penetration and before the person wishes it" (APA, 2000a, p. 552). Similarly to ED, PE is a relatively common sexual dysfunction affecting up to 30% of the population (Leiblum, 2007), which can develop as a result of a variety of interrelated biopsychosocial cofactors. The main

theme in the literature on premature ejaculation is that the male is unable to voluntarily control how rapidly he ejaculates, which causes the male and/or his partner(s) distress. Unlike ED, which is more prevalent in older males, PE can affect males at all ages (Leiblum, 2007).

Orgasmic dysfunction. Males who have orgasmic difficulties or experience anorgasmia are much less common than males who experience rapid ejaculation. Male orgasmic disorder is also not well understood by researchers and adequate literature on the subject is lacking. Lack of understanding and valid assessment of male orgasmic disorder has also inhibited proper treatment of this sexual dysfunction. Similarly to other dysfunctions, male orgasmic disorder can cause its sufferers and their partners serious distress (Ribner, 2010). Male orgasmic disorder may cause physical trauma to sufferers' partners as well as engender feelings of guilt and responsibility for his or her partner's inability to orgasm. At this time, there is minimal effective treatment available for men who experience this sexual problem (Ribner, 2010). The DSM-IV-TR defines male orgasmic disorder as the, "persistent or recurrent delay in or absence of, orgasm following a normal sexual excitement phase" (APA, 2000a, p. 550).

Pain. Male sexual pain disorders are poorly understood by researchers. Often male sexual pain disorders have a biological component, but not always. Additionally, pain disorders are often comorbid with other male sexual dysfunctions, particularly erectile dysfunction and premature ejaculation (Davis, Binik, & Carrier, 2009). Sexual pain disorders can also inhibit sexual desire given that sexual encounters bring about physical pain. Male sexual pain can be experienced in several areas in the male genitals such as the testicles and perineum (Davis, Binik, & Carrier, 2009). Estimates of prevalence rates for male pain disorders approximate that 6% of men experience sexual pain (Babineau & Schwartz, 1977). The DSM-IV-TR calls male

sexual pain dyspareunia and defines this disorder as, “genital pain that is associated with sexual intercourse” (APA, 2000a, p. 554).

Female sexual dysfunction. The DSM-IV-TR identifies hypoactive sexual desire disorder, sexual aversion disorder, female arousal disorder, female orgasmic disorder, vaginismus, and dyspareunia as potential sexual dysfunctions facing females. Similarly to male sexual dysfunctions, female sexual problems may be further specified as situational or generalized, lifelong or acquired, and psychological or combined psychological and biological. Additionally, the dysfunction must cause “marked distress or interpersonal difficulty” in order to be diagnosed as a disorder according to the DSM-IV-TR (APA, 2000a). The most common female sexual problems involve the absence of orgasm, sexual desire, sexual pleasure, or insufficient lubrication (Leiblum, 2007).

Desire. Helen Singer Kaplan introduced sexual desire as an addition to Masters and Johnson’s human sexual response cycle. Since then, definitions of sexual dysfunction have expanded to include hypoactive sexual desire disorder. For females in particular, hypoactive sexual desire can be quite common and estimates indicate that as much as 32% of women experience hypoactive sexual desire (Zakhari, 2009). The DSM-IV-TR does not distinguish between male and female hypoactive sexual desire and thus the diagnostic criteria for the disorder is the same for both sexes. Helen Singer Kaplan was the first researcher to contribute a new dimension to human sexual response following the widespread dissemination of Masters and Johnson’s model. Kaplan’s model for human sexual response accounted for the added dimension of sexual desire. According to Kaplan (1977), lack of desire was a common complaint among clients attending sex therapy, which was generally amenable to treatment.

Basson (2002) argues for a more subjective experience of sexual desire for women and argues against the current definitions of sexual desire as they are based in a rigid understanding of human sexual response and experience. According to this model, sexual desire is not exactly present or absent, but exists in a cycle, which is related to other factors in order for sexual desire to manifest or become inhibited. Basson also argues that sexual desire for women may not be present in all cases, which is unrelated to eventual sexual satisfaction and functionality. This model also argues against the use of pathologizing language and accounts for emotional experience, intimacy, and meanings attributed to sexual experiences (Basson, 2002). Thus, for women in particular, there is disagreement about what constitutes healthy sexual desire and whether or not sexual desire is important for normal sexual function and response.

Arousal. Female sexual arousal disorder, according to the DSM-IV-TR, is the "persistent or recurrent inability to attain, or to maintain until completion of the sexual activity, an adequate lubrication-swelling response of sexual excitement" (APA, 2000a, p.543). Normal arousal response according to the DSM-IV-TR is, "vasocongestion in the pelvis, vaginal lubrication and expansion, and swelling of the external genitalia" (APA, 2000a, p.543). One of the main problems women face with sexual arousal is difficulty lubricating. Prevalence rates of difficulties with vaginal lubrication are as high as 76% according to one study's estimates (West, Vinikoor, & Zolnoun, 2004). Furthermore, arousal can be physical, subjective or both. Recent attention has also been given to a newly defined sexual arousal problem, which is when females experience genital arousal without sexual desire (Leiblum, 2007). This arousal problem has gained researchers' attention, and has been the source of much confusion among professionals and often causes sufferers considerable distress. Problems with physical arousal, subjective arousal,

subjective and physical arousal, and genital arousal without sexual desire or activity constitute the four dimensions of sexual arousal problems in women (Leiblum, 2007).

Orgasm. Orgasm is one of the core dimensions of the human sexual response cycle according to Masters and Johnson. Orgasm has been described as a feeling of release and is characterized by muscle contractions in the genital area, and is typically followed by a period of relaxation (Leiblum, 2007). Orgasmic dysfunctions are among the most prevalent sexual problems facing women. In addition to sexual desire disorders, difficulty achieving orgasm and anorgasmia are estimated to affect up to 63% of women (Harrison, 1987), although more current reports suggest the prevalence is around 28% of women (Zakhari, 2009). According to the DSM-IV-TR, female orgasmic disorder is the, "persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase" (APA, 2000a, p. 547). Women who experience problems with orgasmic function may never have had an orgasm or may have had orgasms in the past and experience difficulties after having been orgasmic (Leiblum, 2007).

Pain. Dyspareunia and vaginismus are the two sexual pain disorders identified in the DSM-IV-TR. The DSM-IV-TR defines dyspareunia as, "genital pain that is associated with sexual intercourse" (APA, 2000a, p. 554) and vaginismus as, "persistent involuntary contraction of the perineal muscles surrounding the outer third of the vagina when vaginal penetration with penis, finger, tampon, or speculum is attempted" (APA, 2000a, p. 556). Vaginismus is a particularly distressing sexual problem for women with unclear etiology and treatment. Vaginismus often has biological and psychological causes and effects and in severe cases can make penetration of any kind impossible (Masters & Johnson, 1970). Sexual pain disorders affect 8-21% of women (Zakhari, 2009).

Prevalence. Prevalence rates of sexual dysfunction are extremely difficult to determine because rates of sexual dysfunction vary based on age, sex, health status, relationship status, and many other factors. Furthermore, certain types of sexual dysfunctions are more prevalent than others, which vary among males and females. According to the literature, prevalence rates of sexual dysfunctions are higher in women, although research consumers should consider critically how these prevalence rates have been measured and determined by previous researchers (Sobczak, 2009a; Zakhari, 2009). There are many factors and co-contributors to prevalence rates of sexual dysfunction for men and women. Thus, being a woman does not *cause* one to be more at risk of having a sexual dysfunction. Prevalence rates have also been difficult to determine based on myriad definitions of what constitutes a sexual dysfunction. Additionally, underreporting of sexual functioning concerns may distort prevalence rates (Zakhari, 2009).

Although men and women both experience a range of sexual concerns, many previous researchers have consistently found that women report sexual concerns more frequently than men (Laumann, Paik, & Rosen, 1999; Sobczak, 2009a; Zakhari, 2009). Additionally, for females, desire and orgasmic disorders have been found to be the most common complaints whereas for males, erectile dysfunction and premature ejaculation are among the most common complaints (Babineau & Schwartz, 1977; Papaharitou, Nakopoulou, Kirana, Iraklidou, Athanasiadis, & Hatzichristou, 2005; Santtila, Sandnabba, & Jern, 2009; Sobczak, 2009a; Sobczak, 2009b; Weismeier & Forsythe, 1982; Zakhari, 2009). Rates of prevalence are higher among older adult populations, among individuals with poorer health status, among non-married individuals, among individuals with low academic attainment, and among individuals with mental health concerns and distress (Davis, Binik, & Carrier, 2009; Laumann, Paik, & Rosen, 1999; Slowinski, 2007). Research on prevalence of sexual dysfunction also generally agrees that

sexual dysfunctions are often comorbid, meaning a person is often experiencing more than one sexual dysfunction or functioning concern (McMahon, Abdo, Incrocci, Perelman, Rowland, Waldinger, & Xin, 2010; Slowinski, 2007). For example, comorbidity of premature ejaculation and erectile dysfunction can be as high as 30% (McMahon, Abdo, Incrocci, Perelman, Rowland, Waldinger, & Xin, 2010). Researchers also agree that sexual functioning concerns affect a considerable percentage of people, due to its systemic effects and reinforcing etiology (Fitter, Hayter, & Wylie, 2009; Harrison, 1987). According to Slowinski (2007), as many as 30 million men in the United States experience erectile dysfunction who likely have sexual partners. Considering the effects of only erectile dysfunction, it becomes clear that sexual functioning concerns are epidemic.

Population estimates for prevalence of sexual dysfunction range from 19-50% of the population (Zakhari, 2009), 25-63% of women (Fitter, Hayter, & Wylie, 2009; Laumann, Paik, & Rosen, 1999; Sobczak, 2009a; Sobczak, 2009b; Zakhari, 2009), 10-63% of men (Fitter, Hayter, & Wylie, 2009; Laumann, Paik, & Rosen, 1999; Sobczak, 2009a; Sobczak, 2009b; Zakhari, 2009), and 45% of couples (Metz & McCarthy, 2007). One study found that sexual dysfunctions are reported by 13% of college students (Spencer & Zeiss, 1987). Prevalence rates for specific sexual dysfunctions have also been reported by a number of researchers. Rates of orgasmic dysfunction range from 8-63% in women (Harrison, 1987) with some researchers reporting 40% prevalence in women (Babineau & Schwartz, 1977), and others reporting 20-50% (West, Vinikoor, & Zolnoun, 2004) and 22-28% prevalence in women (Zakhari, 2009). Reports of orgasmic dysfunction in men demonstrate a similar range of rates from 5.6% (Santtila, Sandnabba, & Jern, 2009) to 77.3% (Davis, Binik, & Carrier, 2009) in men. Babineau and Schwartz (1977) found that 11% of their male student sample reported inability to orgasm

whereas other researchers have found prevalence rates of 7-9% for males' inability to orgasm (Slowinski, 2007). Rates of premature ejaculation range from 28-46% (Santilla, Sandnabba, & Jern, 2009; Slowinski, 2007; Weismeier & Forsythe, 1982).

In addition to orgasmic disorders, sexual desire disorders are among the most prevalent (Kaplan, 1977). Highest estimates of sexual desire dysfunction in women suggest that 27-32% of women experience this dysfunction (Zakhari, 2009). For men, hypoactive sexual desire is related to erectile dysfunction (Slowinski, 2007). Low sexual desire is most prevalent among older men who are three times more likely to experience hypoactive sexual desire than their younger counterparts (Laumann, Paik, & Rosen, 1999). Specific prevalence rates for male hypoactive sexual desire range from 13-17% (Slowinski, 2007). Although pain disorders are not as common as either desire or orgasmic dysfunctions, sexual pain is one of the primary sexual functioning concerns expressed by people and for women in particular. Prevalence rates for sexual pain include 8-24% of women (Babineau & Schwartz, 1977; Zakhari, 2009) and 6% of men (Babineau & Schwartz).

Last, arousal disorders comprise the fourth most common sexual functioning complaint. Arousal disorders generally pertain to lubrication difficulties for women and erectile dysfunction for men. One study suggested that as many as 76% of women experience lubrication problems with older women experiencing greater difficulties with vaginal lubrication (Laumann, Paik, & Rosen, 1999; West, Vinikoor, & Zolnoun, 2004). In a population study of aging males, approximately 35% were found to experience erectile dysfunction (Laumann, Paik, & Rosen, 1999; Slowinksi, 2007). Among adolescent males, the prevalence of erectile dysfunction was 25% (Santilla, Sandnabba, & Jern, 2009). Among males 19-59 erectile dysfunction rates range from 7-18% (Slowinski, 2007).

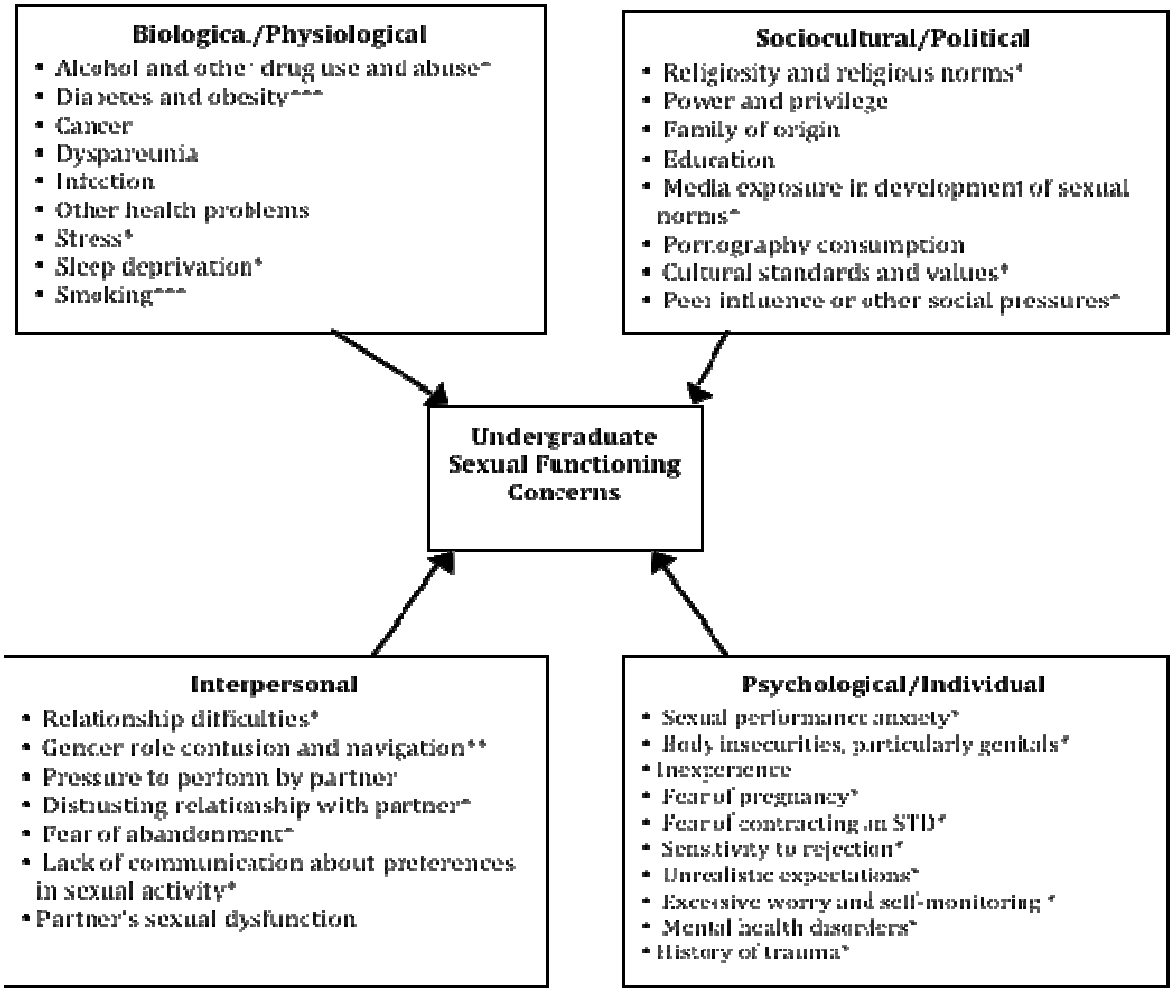
If one broadens the definition of sexual dysfunction to include sexual functioning concerns, prevalence estimates may be even higher. Given the prevalence, sexual functioning concerns can have a range of consequences on emotional, physical, psychological, and interpersonal well-being (Fitter, Hayter, & Wylie, 2009). Thus, regardless of how one defines sexual dysfunction, it is clear that sexual functioning concerns are prevalent and significantly impact one's quality of life (Laumann, Paik, & Rosen, 1999; Slowinki, 2007).

Etiology. Sexual problems develop for a vast range of reasons. For some, sexual functioning concerns coincide with early sexual development (Santilla, Sandnabba, & Jern, 2009). For others, sexual functioning concerns develop following trauma or periods of intense stress, or as a result of a mental disorder (Basson, 2001; Cohen, 2006). For others still, sexual problems can develop following a period of healthy sexual functioning, as a result of a partner's sexual functioning concerns, or as a result of a change in health status (Sobczak, 2009b). Sexual problems are imbedded in complex and interrelated biological, sociocultural, psychological, and interpersonal factors. Zakhari (2009) presented a figure of factors related to female sexual dysfunction, which included the four aforementioned factors. This way of conceptualizing influences on female sexual dysfunction is useful for conceptualizing the factors that influence undergraduate sexual concerns. See Figure 2 for factors that contribute to undergraduate sexual concern. In spite of its multivariate etiology, the biological contribution to sexual concerns has become a primary focus of researchers since the rise of medical interventions to treat sexual functioning concerns (Metz & McCarthy, 2007). However, the reality of most sexual dysfunction is that its cause is multidimensional and psychological and social aspects of sexual problems are being ignored for both men and women (McCarthy & Metz, 2008). Problems do not generally occur in isolation but rather evolve as a complex system of interrelated cofactors (Fitter, Hayter,

& Wylie, 2009). Thus, thorough assessment of the development of sexual functioning concerns is necessary in order to understand the range of multivariate causes and impacts.

For undergraduates, etiology of sexual functioning concerns develop as a result of several biopsychosocial factors that are unique to college students' particular developmental stage and experiences (Cohen, 2006). Specifically, fears related to contracting sexually transmitted diseases and unwanted pregnancy contribute added anxiety for students around sexuality.

Figure 2
Biological, Sociocultural, Interpersonal, and Intrapsychic Factors the Contribute to Sexual Concerns in Undergraduate Students



* Cohen, K. M. (2006). Sexual concerns. In P. A. Grayson, P. W. Mailman, P. A. Grayson & P. W. Mailman (Eds.), *College mental health practice.* (pp. 215-237). New York, NY US: Routledge. ** Spencer, S. L., & Zeiss, A. M. (1987). Sex roles and sexual dysfunction in college students. *Journal of Sex Research, 23*(3), 338-347. *** Leblum, S. R., (2007). Principles and practice of sextherapy *(4th ed.)* New York, NY US: Guilford Press.

Additionally, inexperience and unrealistic expectations, body insecurities, fear of rejection, performance anxiety, trauma, and mental health issues can all be intrapsychic contributors to sexual distress. Interpersonal factors such as lack of communication about sexual preferences, fear of abandonment, pressure to perform, and lack of trust can influence sexual concerns among individuals and their partners. Furthermore, substance use, infections and illness, sleep deprivation, and stress are possible biological and physiological contributors to sexual concerns. Last, one's sociocultural and political context can impact the development of sexual problems. Examples include lack of comprehensive sexuality education, peer influence and social pressures, religious practices, power and privilege, and family structure (Cohen, 2006). Just as one's sociocultural and political context can contribute to the acquisition of sexual knowledge, norms, and practices, so too can this context influence sexual problems. Thus, sexual problems are not *caused* by one's sociocultural and political context, but rather sexual problems are imbedded within and intricately bound *to* one's sociocultural and political context. This is especially true for college students who may be experiencing sexual activity for the first time, navigating their sexual identity, and determining sexual preferences (Butler, O'Donovan, & Shaw, 2010).

Biopsychosocial formation of sexual dysfunction. Given that sexual problems do not occur in isolation, an understanding of the biopsychosocial formation of sexual dysfunction is imperative. Interpersonal, intrapsychic, sociocultural, and biological factors are all important to understand human sexual behavior as well as to understand when sexual problems arise. Conceptualizing sexuality through a biopsychosocial lens allows for more variation in sexual behavior and experience, which also allows for a broader conceptualization of sexual dysfunction (Basson, 2003). Understanding sexual problems as embedded in a multivariate

context allows for a comprehensive view of the concerns an individual and his or her partner(s) may be facing as well as informs mental health and medical professionals' approach to assessment, diagnosis, and treatment (Metz & McCarthy, 2007). In this way, mental health and medical professionals avoid oversimplifying what is often a complex and dynamic issue for individuals and their partner(s). By understanding the complexities of sexual functioning concerns, mental health and medical professionals may begin to address an epidemic quality of life issue and public health concern at the micro level (Metz & McCarthy).

Sexual response cycle. Rather than discussing sexual functionality based on ability to perfect each stage of the sexual response cycle, it may be more useful to base functionality on sexual pleasure. Regardless of the mastery of each level of the sexual response cycle, did the person feel satisfied with their sexual experience or gain sexual pleasure from the experience? This question is not often asked when discussing prevalence and creating definitions for sexual dysfunction. In order to understand dysfunctional sexual behavior, it is important to understand people's motivations for sexual activity, which range, but often include the quest for sexual pleasure. Thus, if sexual pleasure is achieved, a person may not consider their sexual lives to be dysfunctional regardless of whether or not they successfully navigated through the sexual response cycle (Metz & McCarthy, 2007).

Definitions of healthy sexual functioning are rooted in an acceptance of the human sexual response as normal sexual behavior. Based on definitions of human sexual response to understand normal sexual functioning, one can begin to construct an understanding of abnormal sexual functioning. However, Masters and Johnson's original sexual response cycle has been criticized for its lack of acknowledgement of the complexities and variability in human sexual response. Thus, a greater acceptance of subjective sexual experience from a postmodern

worldview will evolve the current understanding of sexual function and dysfunction. Basson (2001) suggests a new sexual response cycle, which allows for nuanced sexual response and a greater emphasis on the contextual factors that contribute or inhibit sexual response.

Masters and Johnson. Masters and Johnson made a significant contribution to research in sexuality when they studied and published findings of physiological sexual response in humans. Masters and Johnson studied and observed numerous participants to establish the four phases of the human sexual response cycle, which include excitement, plateau, orgasm, and resolution (Masters & Johnson, 1966). Since its inception over forty years ago, the model has been criticized, but is still widely accepted as the gold standard for understanding physiological sexual response in humans.

Excitement. According to Masters and Johnson, at this phase in the sexual response cycle, individuals can become subjectively and/or physically aroused. In this phase, sexual tension is building through genital stimulation. The length of the excitement phase varies and can intensify individual's subjective and/or physical arousal if stimulation is maintained or intensified (Masters & Johnson, 1966).

Plateau. Once arousal is sufficiently obtained in the excitement phase, individuals move to the plateau phase of the sexual response cycle. In this phase, original sexual tension is intensified and reaches the highest levels. The length of this phase varies depending on the type and intensity of the stimuli producing arousal and tension. If stimulation is inadequate, individuals may not move to the orgasm phase. If this occurs, tension levels will slowly decrease and individuals will move to the resolution phase (Masters & Johnson, 1966).

Orgasm. The orgasm phase occurs when sufficient sexual tension has been built in the first two phases. The orgasm phase only lasts a few seconds and occurs when vasocongestion

that has been built during the first two phases is released. This phase is the highest level of sexual tension in the sexual response cycle. Orgasmic response occurs in the clitoris, vagina, and uterus for females and in the penis, seminal vesicles, and prostate for males. Subjective experience of orgasm varies among individuals. Female orgasmic experience varies greatly from female to female, whereas male orgasmic experiences are more similar (Masters & Johnson, 1966).

Resolution. From the orgasm phase, individuals move into the fourth and final phase of the human sexual response cycle. At this phase, sexual tension decreases until the individual is no longer sexually aroused. This process can be slow for both males and females. Females at this phase may also reenter the orgasm phase and may vacillate back and forth between these two phases before she is completely unstimulated. Every phase of the sexual response cycle varies in intensity and duration depending on the individuals involved (Masters & Johnson, 1966).

Kaplan. Helen Singer Kaplan expanded Masters & Johnson's human sexual response cycle to include sexual desire. In Kaplan's conceptualization of human sexual response, she includes three phases, which are desire, excitement, and orgasm (Kaplan, 1979).

Desire. Desire was an important addition to the research on human sexual response. According to Kaplan, Masters and Johnson's model only included physiological sexual response. In her model, inhibited sexual desire can negatively affect the entire sexual response cycle because it serves as the psychological foundation from which physiological phases derive. Absence of sexual desire can inhibit excitement and orgasm and is considered an important aspect of sexual response (Kaplan, 1979).

Excitement. Kaplan's excitement phase corresponds with Masters and Johnson's excitement and plateau phases. In this phase, according to Kaplan, female and male genitals

change shape due to vasodilatation. This phase is preparation for sexual activity in which the male penis becomes erect and the female vagina becomes lubricated (Kaplan, 1979).

Orgasm. Kaplan's orgasm phase corresponds with Masters and Johnson's conceptualization of the orgasm phase. At this phase of sexual response, male and female genital muscles contract. For males, orgasm includes emission and ejaculation. For females, orgasm is similar to male ejaculation. Male and female orgasms are generally experienced as a pleasurable sensation (Kaplan, 1979).

Basson. Basson argues that expanded conceptualization of human sexual response will provide a broader understanding of sexual problems (Basson, 2001). Her suggestions for expanding the human sexual response enable greater variability among human's subjective sexual experiences. This model also emphasizes that sexual response is not simply biological and/or psychological, which are considered only minimally informative and represent generally mechanistic thinking (Basson, 2001). A contextual understanding of human sexuality allows for sexual response to be based on complex biopsychosocial and spiritual factors. In this model, Basson argues for a broader acceptance of a range of normal sexual responses (Basson, 2001).

Help-Seeking

Background. Mental health services have been consistently underutilized for a range of presenting issues despite a high prevalence of mental health concerns among people who live in the United States (Vogel, Heimerdinger-Edwards, Hammer, & Hubbard, 2011). According to Gourash (1978), help-seeking is, "any communication about a problem or troublesome event which is directed toward obtaining support, advice, or assistance in times of distress" (Gourash, 1978, p. 414). This definition helps clarify the meaning of help-seeking and expresses the various ways in which one can seek help as well as exemplifies the quality of the help sought by

an individual. The literature on help-seeking suggests that underutilization is more prevalent among certain age groups, ethnic groups, sexes, and socio-economic groups.

Generally, women are more likely than men to hold more positive attitudes toward help-seeking from mental health professionals and are more likely to seek help from mental health services (Morrell & Metzl, 2006; Nam, Chu, Lee, Kim, & Lee, 2010; Tsan, Day, Schwartz, Kimbrel, & 2011). In fact, men who ascribe to a more traditional masculine gender role are significantly more likely to express negative attitudes toward help-seeking than their less traditional masculine counterparts (Nam, Chu, Lee, Kim, & Lee, 2010). However, the prevalence of males seeking professional mental health has been increasing over the last several years (Morrell & Metzl, 2006). Among Asian Americans, gender differences in attitudes toward help-seeking are less marked (Nam, Chu, Lee, Kim, & Lee, 2010). Additionally, help-seeking declines with age (Gourash, 1978). There have also been trends in the literature on help-seeking that suggest that help-seeking is more prevalent among Caucasians than African-Americans (Gourash, 1978). Some have hypothesized that Latinos are less likely to utilize professional mental health services for a variety of reasons, including a preference to solve family and emotional problems within the family (Bermúdez, Kirkpatrick, Hecker, Torres-Robles, 2010). Regardless of age, sex, ethnicity, race, and socioeconomic status, people generally seek help from informal sources such as friends, family, religious leaders, co-workers, and teachers before seeking professional help for mental distress (Morrell & Metzl, 2006). This suggests that individuals utilize numerous help sources before they consider seeking formal help. This may be especially true for sexual concerns, given the sensitive nature of the topic.

Help-seeking for sexual functioning concerns. According to the literature on help-seeking for sexual functioning distress, prevalence of sexual functioning distress is high yet

services that address such distress are underutilized (Shifren, Johannes, Monz, Russo, Bennett, & Rosen, 2009). In a study that addressed the help-seeking behaviors of women, younger women and women who had a romantic partner(s) were more likely to seek help for sexual functioning concerns. For sexual functioning distress, individuals are more likely to seek out informal or anonymous sources due to embarrassment and stigma (Shifren, Johannes, Monz, Russo, Bennett, & Rosen, 2009). According to Fitter, Hater, & Wylie (2009), there is an extensive decision-making process for seeking help for sexual functioning concerns, which include interpreting perceptions from internal and external sources, seeking opinions from others, making a decision, and evaluating the decision. At any point in this process a person could reconsider, based on myriad barriers, the decision to seek help and subsequently not follow through.

Rates of help-seeking utilization. Rates for help-seeking vary widely depending on the demographics of the participants being asked and the type of problem causing distress. One study found that approximately one third of their sample sought help for a range of mental health concerns (Gulliver, Griffith, Christiansen, 2010). Another study estimated that help-seeking prevalence ranged from 11-30% in any particular year (Vogel, Heimerdinger-Edwards, Hammer, & Hubbard, 2011). Due to countless barriers to mental health treatment, a 2004 report on the state of mental health and treatment in the United States suggest that one in three people are not getting the help that they need with regard to mental health distress (Therapy in America, 2004). This report also suggests that in a two-year period, approximately 30% of Americans have been in need of treatment for mental health distress (Therapy in America, 2004). This prevalence rate is double that of the prevalence rates determined in a 1978 President's Commission, which found that only 15% of Americans was in need of treatment for mental health distress (Morrell & Metzl, 2006). This increase in mental health distress and need for treatment is coupled with

increased service utilization from 1978 to 2004 (Morrell & Metzl, 2006). The increase in mental health utilization is promising for mental health professionals; however, it is still widely stated in the literature that mental health services are largely underutilized (Gulliver, Griffiths, & Christensen, 2010; Nicolosi, Laumann, Glasser, Brock, King, & Gingell, 2006; Shifren, Johannes, Monz, Russo, Bennett, & Rosen, 2009; Slowinski, 2007). The increase in service utilization may not hold true when researchers delineate mental health distress by specific problems. For example, seeking help for an alcohol or substance use problem may still be restricted. According to a study of undergraduates, only 18.3% of participants sought help for a problem related to alcohol, which was primarily by talking to friends and family members about the problem (Buscemi, Murphy, Martens, McDevitt-Murphy, Dennhardt, Skidmore, 2010). Additionally, prevalence for help-seeking significantly diminishes when the problem causing distress is related to sexual functioning concerns. For sexual functioning concerns, one study found that slightly more than one third of women in the sample had ever received help for a sexual functioning concern (Shifren, Johannes, Monz, Russo, Bennett, & Rosen, 2009). This rate is approximately half of the current trends for other mental health problems, which indicate that approximately 63% are receiving treatment for other mental health concerns (Therapy in America, 2004). Prevalence rates for help-seeking show that mental health professionals may be becoming more accessible and less stigmatized, yet a gap in services still exists, especially for sexual functioning concerns.

Rates of utilization of help-seeking for sexual functioning concerns. Rates for seeking help for sexual concerns tend to be lower than prevalence rates for other distressing mental health issues. One study stated that only 6% of women who received help for a sexual functioning concern went to a care provider to specifically address the sexual problem (Shifren,

Johannes, Monz, Russo, Bennett, & Rosen, 2009). This means that although others may have received help for a sexual problem, most others receive help as a consequence to seeking help for an unrelated concern. This suggests that prevalence for seeking help specifically for a sexual problem is low. Additionally, gynecologists and physicians are generally among the most prevalent service providers. However, one study found that 66% of women have never received any form of help for a sexual functioning concern (Shifren, Johannes, Monz, Russo, Bennett, & Rosen, 2009) while another found that 75% of a sexually active sample had not sought help from a medical professional for a sexual problem (Nicolosi, Laumann, Glasser, Brock, King, & Gingell, 2006). These prevalence rates suggest that underutilization of professional help is high among individuals with sexual functioning concerns. Furthermore, 80% of women reported that they prefer that their healthcare provider broaches the topic of sexual functioning concerns (Shifren, Johannes, Monz, Russo, Bennett, & Rosen, 2009). However, it has been suggested that only 14% of individuals aged 40-80 have been asked about sexual functioning concerns by a healthcare provider (Zakhari, 2009). Also, 71% of the sample in one study reported that they thought their primary care doctor would dismiss their sexual functioning concerns if they were brought up (Fitter, Hayter, & Wylie, 2009). These findings can only have one outcome; sexual functioning concerns are not being addressed nearly as frequently as they are being experienced.

Barriers to help-seeking. Researchers have identified a plethora of barriers that individuals, couples, and families experience with regard to seeking help for mental health distress. Even once an individual has overcome initial barriers and decided to seek treatment, 40% of people do not return to therapy after the initial session (Morrell & Metzl, 2006). Barriers to help-seeking for mental health distress can be due to practical, attitude, intrapsychic, and clinical-professional factors. Possessing certain demographic traits as well as personal attitudes

toward and comfort with self-disclosure may serve to inhibit help-seeking (Vogel & Wester, 2003). Attitude factors such as stigma about mental health services, mental health professionals, and perceived self-stigma and meaning attribution for seeking help including vulnerability, weakness and failure may also inhibit help-seeking (Gulliver, Griffith, & Christensen, 2010; Vogel, Heimerdinger-Edwards, Hammer, & Hubbard, 2011). Other common attitude factors that serve as barriers to help seeking include preference for self-reliance, pessimism about successful treatment outcomes, negative past experience, lack of trust in the mental health system including concerns about confidentiality and inability to remain anonymous (Gulliver, Griffith, & Christensen, 2010), and preference for informal help sources such as friends and family (Morrell & Metzl, 2006).

One commonly cited intrapsychic variable that prevents people from seeking help is embarrassment (Gulliver, Griffith, & Christensen, 2010). In fact, perceived stigma and embarrassment were cited among the two most prominent barriers to help-seeking (Gulliver, Griffith, & Christensen, 2010). Other intrapsychic factors that lead to help-seeking avoidance include poor problem insight, fear of change, fear of judgment, fear of being stereotyped (Morrell & Metzl, 2006), gender role subscription, difficulty relinquishing control (Vogel, Heimerdinger-Edwards, Hammer, & Hubbard, 2011), and restrictive emotionality (Tsan, Day, Schwartz, Kimbrel, & 2011). Level of distress has also been noted as a barrier to seeking help. In fact, individuals' may alter the meaning of increasing distress as a way to avoid seeking formal help (Gulliver, Griffith, & Christensen, 2010). Thus, individuals' level of distress will be accommodated as a way to avoid seeking help for mental health concerns.

Other barriers to seeking professional help include factors of mental health workers and clinician-client factors. Examples of these clinical-professional barriers include incongruent

worldviews between clinician and client, being deterred by personal qualities of the clinician, unmatched demographic variables, and clincians' lack of credibility (Gulliver, Griffith, & Christensen, 2010). Finally, there are several practical concerns that individuals face that may prevent them from seeking professional help. These practical barriers include transportation issues, cost and lack of insurance coverage, inconvenience and inaccessibility, lack of time, misinformation and not knowing where to go, waitlists, and lack of anonymity in public waiting rooms (Gulliver, Griffith, & Christensen, 2010; Morrell & Metzl, 2006).

Taken together, these intrapsychic, clinical-professional, practical, and attitude barriers serve to create a gap in the experience of mental health distress and working to alleviate that distress. Researchers have often focused on the qualities that an individual possesses such as attitude factors and intrapsychic factors in order to overcome barriers and increase access to mental health services. However, it may be more useful to consider the practical and clinical-professional barriers as a way to bridge the gap in services. Mental health professionals are tasked with working around these systematic barriers in order to increase accessibility by alleviating practical and clinical-professional barriers for potential clients.

Barriers to help-seeking for sexual functioning concerns. Embarrassment is a barrier to seeking help for general mental health concerns, and especially for sexual health and functioning concerns. Given that sexuality is often a tabooed topic, embarrassment is one primary reason that individuals are reluctant to seek help. Poor health and depression are often related to increased prevalence of sexual functioning concerns, yet both of these variables serve as barriers to seeking professional help (Shifren, Johannes, Monz, Russo, Bennett, & Rosen, 2009). Most of the barriers identified for general mental health concerns hold true for sexual functioning concerns; however, the problem content itself acts as an added barrier given that there is much stigma

associated with sexuality and sexual dysfunction. Zakhari's (2009) figure of factors related to female sexual dysfunction is also useful for conceptualizing the various barriers to help-seeking for undergraduate students. See Figure 3 for factors that contribute to barriers to seeking professional help for sexual functioning concerns.

Figure 3
Practical, Clinical-Professional, Attitude, and Intrapsychic Factors that Contribute to Barriers to Seeking Professional Help

*Gulliver, A., Griffiths, K. M., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: A systematic review. *BMC Psychiatry, 10*. doi:10.1186/1471-244X-10-113 ** Morrell, M., & Meryl, M. (2006). Seeking treatment in California: motivations, barriers and perceptions. *CAMFT Journal, The Therapist*. *** Vogel, D. L., Heimerdinger-Edwards, S., Hammer, J. H., & Hubbard, A. (2011). "Boys don't cry": Examination of the links between endorsement of masculine norms, self-stigma, and help-seeking attitudes for men from diverse backgrounds. *Journal of Counseling Psychology, 58*(3), 368-382. doi:10.1037/a0023688 **** Tsan, J. Y., Day, S. X., Schwartz, J. P., & Kimbrel, N. A. (2011). Restrictive emotionality, BIS, BAS, and psychological help-seeking behavior. *Psychology of Men & Masculinity, 12*(3), 260-274. doi:10.1037/a0021636

Help-seeking facilitators. Given the abundance of reasons why individuals might not seek mental health services, it is a wonder anyone seeks help for mental health distress. However, there are several facilitating factors for seeking professional help. Factors that increase help-seeking include having a positive past experience, strong social and familial support and encouragement, high educational attainment, longer duration of mental health distress, and influence of a significant other(s) (Gulliver, Griffith, & Christensen, 2010; Morrell & Metzl, 2006). Additionally, a higher degree of emotional intelligence, problem recognition, positive attitudes and fewer stigmas about the mental health field and mental health professionals, and trust in mental health professionals facilitate help-seeking (Gulliver, Griffith, & Christensen, 2010). Furthermore, individuals who have a higher internal locus of control and perceive that their friends would seek help expressed greater willingness to seek help (Harrison, 1987). In sum, more positive attitudes toward help-seeking and greater social and familial support as well as intensity and duration of symptoms increase individuals' likeliness to seek help for mental health distress. Note, the literature on help-seeking facilitators generally does not address factors of mental health professionals or other clinical-professional factors as ways to increase help-seeking. The question remains, what can mental health professionals do to help facilitate help-seeking in individuals who face barriers?

Facilitators of help-seeking for sexual functioning concerns. There are several facilitators of seeking help for sexual functioning concerns, which include being married or in a romantic relationship, experiencing a high level of distress, trust in their provider (Shifren, Johannes, Monz, Russo, Bennet, & Rosen, 2009), and approachability of and comfort with mental health and medical professionals (Fitter, Hayter, & Wylie, 2009). Similarly to barriers for

help seeking for general concerns, facilitators of help-seeking for general concerns are also facilitators of help-seeking for sexual functioning concerns.

Formal, informal, and anonymous help sources. Depending on a multitude of individual, interpersonal, sociocultural, clinical-professional, and practical factors, individuals may seek help for mental health distress from a variety of help sources. There are three main types of help sources, which include formal, informal, and anonymous sources. Often, individuals will seek help from informal sources such as friends, family, and neighbors for mental health distress first before seeking help from mental health professionals (Gourash, 1978; Gulliver, Griffith, & Christensen, 2010). Examples of other informal help sources include clergy, teachers, and mentors. Formal help sources include mental health professionals such as psychiatrists, psychologists, marriage and family therapists, social workers, professional counselors, and psychiatric nurse (Morrell & Metzl, 2006). Medical professionals also comprise a group of formal help sources, which include primary care physicians and gynecologists. Anonymous sources include newspapers, magazines, television, informational pamphlets, help-lines, and the internet. Individual preferences for help sources vary greatly and individuals may elect to utilize only formal sources, only anonymous sources, only informal sources, or any combination of these with infinite variability depending on a multitude of factors. The current study focused on gaining a deeper understanding of the preference for utilizing help sources as well as provider preferences among undergraduate students with sexual functioning concerns.

Provider preference. Individuals, couples, and families may seek help from a variety of sources. Among mental health professionals, there are several ways in which people decide which type of provider to see for mental health distress, which include mental health professionals covered by insurance, physicians recommendations, and location (Morrell &

Metzl, 2006). However, these factors do not address considerations for therapist-client fit, therapist approach, and therapist style, which are equally important factor to consider when determining which mental health professional utilize (Morrell & Metzl, 2006). Additionally, specific types of mental health professionals may be preferred over others depending on the content of the presenting concern. For example, someone suffering from schizophrenia may prefer seeking help from a psychiatrist in order to work closely with a therapist who is able to manage medication. Another person who is experiencing marital distress may prefer to seek help from a marriage and family therapist. In fact, marriage and family therapists are among the type of mental health professionals that individuals would most likely recommend to friends (Morrell & Metzl, 2006; Murstein & Fontaine, 1993). In addition to seeking help based on presenting concerns, misinformation, misunderstanding, or lack of knowledge about a particular mental health field may make certain types of mental health professionals more utilized (Murstein & Fontaine, 1993). In a study of provider preferences, individuals reported feeling significantly less comfortable with a psychiatrist than a psychologist (Murstein & Fontaine, 1993). Similarly to the research on barriers to help-seeking, research on provider preference often focuses less on how mental health professionals play a role in access to services.

Provider preference for sexual functioning concerns. The literature on provider preferences and sexual functioning concerns often focus on provider preferences among medical professionals. There are several help sources that specifically address sexual health and functioning, which include Planned Parenthood, sex therapists, sex educators, sex counselors, and sexuality peer educators. Following an extensive literature search, there is minimal information on service utilization and provider preferences that specifically address sources for sexual functioning concerns. In addition to these specific sexual health and functioning

providers, marriage and family therapists are among those who frequently address sexual health and functioning. However, little research has been done that addresses provider preferences among sexual health and functioning sources. The current study aims to provide a more comprehensive picture of provider preferences among these help sources.

The Current Study

Individuals who experience sexual functioning concerns and sexual dysfunction have a multitude of treatment options. However, given the current trends in help-seeking, individuals are not utilizing the treatment available to them. If individuals do not seek help, they cannot benefit from useful therapeutic interventions. Individuals may experience limitations to accessibility of services given that researchers have identified the same trend in help-seeking for sexual concerns for over 30 years. Misinformation and accessibility to services for a diversity of clients contribute to this gap in help-seeking, which can be alleviated by mental health and medical professionals themselves.

For the current study, sexual functioning concerns were assessed using a variety of measures to examine the occurrence and type of sexual functioning concerns in the current sample of undergraduate students. A general sexual behaviors questionnaire was utilized to assess participants' sexual history. The study was a supplement to previous research in that it merged the literature on sexual dysfunction and help-seeking practices, while aiming to identify gaps in the accessibility of mental health services. The study assessed college students' needs regarding sexual functioning concerns and provided a deeper understanding of the current trends in help-seeking among undergraduates. Additionally, the study aimed to identify barriers to service utilization that may be useful for mental health professionals in the future. For study participants, evaluating their own help seeking behaviors and service utilization may have

increased their awareness of options for therapy and made other avenues accessible to students who struggle with healthy sexual functioning. Many studies on sexuality look at undergraduate populations because they are an accessible population and results are then used to generalize to the public (Wiederman, 2001). However, less research has been conducted that specifically aims to better understand undergraduate sexuality. The current study specifically investigated undergraduate students to understand what they are experiencing with regard to sexual function and dysfunction.

Undergraduate students are among those who experience high prevalence of sexual concerns and underutilize professional services (Harrison, 1987). Thus, a study that focused on assessing specific sexual concerns and subsequent help-seeking behavior can identify gaps in services for this particular sample. Sexuality researchers frequently use undergraduate samples due to their overall willingness to participate and accessibility (Weiderman, 2001). The current research utilized a sample of undergraduate students to gain a deeper understanding of the specific concerns, behaviors, and needs in this sample.

The specific research questions that were addressed in this study include the following: 1.) What types of sexual functioning concerns are most common among a sample of undergraduate students?; 2.) What types of help sources do undergraduates seek out most often for sexual functioning concerns?; 3.) What types of mental health professionals are utilized most frequently among undergraduates with sexual functioning concerns?; and 4.) What attitudes do undergraduate students possess about seeking professional help and what are the barriers undergraduate students identify for seeking professional help for sexual functioning concerns?

CHAPTER 3: METHODOLOGY

Participants

The sample consisted of 347 undergraduate students representing a range of races, ages, ethnicities, and sexes at the sampled institution. Participants were eligible to take part in the study if they met the following inclusion criteria: 1.) Participants were undergraduate students; and 2.) Participants were over 18. Participants opted into the study by confirming that they were undergraduate students and over the age of 18. Thus, students could only participate in the study if they met these requirements.

Procedure

Participants for this study were recruited via student announcement listservs. Through this modality, the researcher announced information about compensation, time required for participation, a brief overview of the study including inclusion criteria, and a link to the questionnaire. The announcement was sent at the beginning of January 2012 and continued to be available through February 2012. All questionnaires were completed online via psychsurveys.org, which is a website that allows researchers to create and manage surveys and analyze data free of charge (see www.psychsurveys.org). Participants were compensated by giving their email addresses for a drawing for one of two $50 Visa™ gift cards.

Participants read an information sheet, confirmed that they were at least 18 years of age, were an undergraduate student, and then indicated their consent to participate. Participants reported a sex of male or female and were directed to the appropriate questionnaires for their sex.

Measures

Sexual functioning concerns were assessed in males using the Index or Premature Ejaculation (IPE) and the International Index of Erectile Function (IIEF). Sexual functioning

concerns were assessed in females using the Female Sexual Functioning Index (FSFI). Sexual satisfaction was assessed using the female and male versions of the Sexual Quality of Life Scale (SQOLF and SQOLM). Help-seeking attitudes were assessed using the Attitudes Toward Seeking Professional Psychological Help Scale Short Form (ATSPPHS-SF). History of sexual behaviors was assessed using questions from the Sexual Adjustment Inventory (SAI). The questionnaire also included the Major Depression Inventory (MDI) and the Generalized Anxiety Disorder 7-item Scale (GAD-7) to assess depression and anxiety, respectively. Given that depression and anxiety are often linked to changes in sexual functioning (Frohlich & Meston, 2002; Shifren, Johannes, Monz, Russo, Bennett, & Rosen, 2009), the researcher included these measures to account for anxiety and depression as salient variables in sexual functioning among college students. Each of these scales has demonstrated sound psychometric properties including high internal consistency and test-retest reliability.

The researcher developed items related to formal and informal help sources they have utilized, are currently utilizing, and/or will utilize in the future in order to assess past, present, and future help-seeking behaviors. Provider preferences among mental health professionals were assessed by the researcher through questions developed for use in this study. Demographic questions include sex, sexual orientation, year in school, age, race, ethnicity, health status, level of alcohol use, relationship status, STD status, and employment status. See Appendix A for full questionnaire.

Functioning Questionnaires

FSFI. The FSFI was designed to assess the following dimensions of female sexual dysfunction: desire, arousal, lubrication, orgasm, satisfaction, and pain (Rosen, Brown, Heiman, Leiblum, Meston, Shabsigh, Ferguson, & D'Agostino, 2000). Additionally, the FSFI is brief and

higher scores on the FSFI indicate healthier sexual functioning (Farmer & Meston, 2007). According to Zakhari (2009), the measure has successfully discriminated between types of sexual disorders and has strong psychometric properties. Furthermore, robust reliability estimates have been demonstrated with some samples with tests for internal consistency and test-retest reliability yielding Cronbach's *alpha* = .79-.88 and *r* = .89-.97, respectively (Farmer & Meston, 2007). Analyses of the FSFI subscales yielded Cronbach's *alpha* = .72-.98 (Ter Kulie, Brauer, & Laan, 2006). Additionally, inter-item correlations among subscales yielded *r* = .41-.95, test-retest reliability was demonstrated, and statistical tests revealed 93.7% predictive validity (Ter Kulie, Brauer, & Laan, 2006). Also, for each of the four dimensions of female sexual functioning concerns assessed by the index, Cronbach's *alpha* consistently yielded scores of .84 and above (Farmer & Meston, 2007).

IIEF. The IIEF is a widely used measure to assess the presence and severity of erectile dysfunction (Rosen, Riley, Wagner, Osterloh, Kirkpatrick, & Mishra, 1997). The measure has been translated into 32 different languages and is considered a sound measure for assessing erectile dysfunction and meets robust psychometric reliability and validity criteria (Rosen, Cappelleri, & Gendrano, 2002). The IIEF has demonstrated high internal consistency (Cronbach's *alpha* = .73-.99) and test-retest reliability (*r* = .64-.84). Discriminant, convergent, and divergent validity were all assessed and demonstrated to be significant for the IIEF (Rosen, Cappelleri, & Gendrano, 2002).

IPE. The IIEF is a sound measure of erectile dysfunction, but it does not assess other types of male sexual dysfunctions such as premature ejaculation. Althof and colleagues designed the Index of Premature Ejaculation (IPE) in 2006 (Althof, Rosen, Symonds, Mundayat, May, & Abraham, 2006). The IPE is a 10-item measure that assesses three domains of premature

ejaculation including sexual satisfaction, ejaculatory control, and distress related to premature ejaculation. Internal consistency, test-retest reliability, and convergent validity were demonstrated. Chronbach's *alpha* for internal consistency yielded a score of .7 or higher for all three measure domains. Test-retest reliability also yielded scores of higher than .6 for all three domains (Althof, Rosen, Symonds, Mundayat, May, & Abraham, 2006).

Satisfaction and Attitudes Questionnaires

SQOLM and SQOLF. To assess participants' satisfaction with their sexual life, the Sexual Quality of Life measure for males and females or SQOLM and SQOLF, respectively, were utilized. The SQOLF has demonstrated sound psychometric properties including internal consistency, discriminant validity, and convergent validity (Symonds, Boolell, & Quirk, 2005). The SQOLM is also a valid and reliable measure for assessing satisfaction with sexual life in males (Abraham, Symonds, & Morris, 2008). This scale is similar to the SQOLF, but addresses aspects of sexuality that are specific to males.

ATSPPHS-SF. Attitudes toward seeking help from mental health professionals were assessed using the Attitudes Toward Seeking Professional Psychological Help Scale Short Form version (ATSPPHS-SF). This scale is a 10-item questionnaire designed to assess individuals' attitudes about seeking treatment for mental health concerns from mental health professionals. The shortened form of this questionnaire was adopted from its original form, which comprised of 29-items (Fischer & Farina, 1995). This shortened assessment is useful in the current study to reduce the amount of time required by participants to complete the study. This measure has yielded internal consistency scores ranging of .82-.84, test-reliability of .8 and correlates .87 to the original 29-item ATSPPHS (Elhai, Schweinle, & Anderson, 2008).

Behavior Questionnaires

Sexual behavior questionnaire. The author created a questionnaire utilizing questions from the Sexual Adjustment Inventory (Stuart, Stuart, Maurice, & Szasz, 1975) that assessed participants' sexual history including past experiences and behaviors. The full version of the Sexual Adjustment Inventory included additional questions, which largely assessed couple dynamics related to sexuality. These questions were excluded from the current study as these questions were outside the scope of the study. Questions were selected on the basis of relevance to the topic of interest and to avoid redundancy in questions.

Alcohol use. The author developed questions to assess participants' alcohol consumption. Since alcohol consumption is typical behavior for undergraduates, which has also been shown to affect sexual functioning (Cohen, 2006; Sobczak, 2009a), it is possible that sexual dysfunction that occurs in the undergraduate population may be due to alcohol consumption for certain individuals (Cohen, 2006). Accordingly, the study asked a question about frequency of sexual problems resulting from alcohol use. The question stated, "Rate your level of alcohol use" with ratings ranging from 1 (never) to 5 (always). The study also asked participants to rate their perceived frequency of drinking as it compares to other undergraduate students drinking behaviors. This was asked to assess the relationship between alcohol consumption and problematic sexual functioning for these individuals. Asking about alcohol use was important in this particular population given that as many as 45% of undergraduate students in the United States report binge drinking periodically (Buscemi, Murphy, Martens, McDevitt-Murphy, Dennhardt, & Skidmore, 2010). Furthermore, it is possible that individuals who find that their own sexual functioning concerns are related to alcohol consumption may be even less likely to seek help given that the etiology of the problem could be established and thus a solution as well.

Service utilization and provider preference. The author developed a questionnaire to evaluate participants' help-seeking behavior and provider preferences, which included questions about their past, present, and potential future help seeking behaviors and provider preferences regarding sexual concerns. These questions asked the participant what types of informal and formal help they have sought in the past, are currently seeking, or would consider seeking in the future for sexual concerns. Informal help sources included friends, family members, teachers, religious leaders and officials, peer educators, mentors, magazines, the Internet, television, newspaper, informational pamphlets, and help-lines. Formal help sources included gynecologists, primary care physicians, mental health professionals, Planned Parenthood, and sex educators. Furthermore mental health provider preferences were assessed. The participants were asked what type of mental health professional they have sought help for in the past, are currently seeking help from, or would consider seeking help from in the future for sexual concerns. Mental health providers that were included are psychiatrists, psychologists, professional counselors, social workers, marriage and family therapists, psychiatric nurses, sex counselors, and sex therapists. This was designed to provide an in-depth perspective on what student participants prefer with regard to seeking help from mental health professionals.

Mental Health Questionnaires

MDI. The Major Depression Inventory Second Edition (MDI) was utilized to assess participants' depressive symptoms (Olsen, Jensen, Noerholm, Martiny, & Bech, 2003). Given that research has shown that depression and sexual dysfunction are highly correlated (Frohlich & Meston, 2002; Shifren, Johannes, Monz, Russo, Bennett, & Rosen, 2009), assessing for participants' depressive symptoms is imperative for the current study. The MDI is a 12-item measure that assesses nine symptoms of depression according to the DSM-IV-TR with total

scores ranging from 0-60 with higher scores indicating more severe depression (Cuijpers, Boluijt, & van Straten, 2008). The MDI has consistently demonstrated reliability and validity and has been utilized by many researchers and clinicians to screen for depressive symptoms. Cuijpers, Dekker, Noteboom, Smits, and Peen (2007) found that the MDI demonstrated convergent validity and internal consistency. Additionally, Cronbach's *alpha* for internal consistency has yielded a score of .89 for the MDI and it has demonstrated validity (Cuijpers, Bolujit, & van Straten, 2008).

GAD-7. The Generalized Anxiety Disorder 7-item Scale was utilized to assess participants' anxiety symptoms (Spitzer, Kroenhe, Williams, & Lowe, 2006). Similarly to depression, anxiety symptoms have also been associated with changes in sexual functioning (Frohlich & Meston, 2002; Shifren, Johannes, Monz, Russo, Bennett, & Rosen, 2009). The GAD-7 categorizes scores into three levels of anxiety ranging from 0-21 with higher scores indicating severe levels of anxiety and lower scores indicating mild or moderate anxiety. According to Löwe, Decker, Müller, Brähler, Schellberg, Herzog, and Herzberg, (2008), the GAD-7 demonstrated internal consistency with Chronbach's *alpha* equaling .89 and construct validity. According to Hallgren and Morton (2007) the GAD-7 is an effective and empirically-based screening tool for anxiety symptoms. Due to its brevity and sound psychometric properties, this assessment of anxiety was an ideal measure for the current study.

CHAPTER 4: RESULTS

The purposes of this study were: 1.) To evaluate the occurrence of sexual functioning concerns in a sample of undergraduate students and identify the sample's most common concerns; 2.) To assess attitudes toward seeking help as well as past, present, and future utilization of formal and informal help sources for sexual functioning concerns; and 3.) To identify provider preferences among mental health professionals in order to identify potential barriers for underutilized mental health fields. Using data obtained from an online questionnaire, sexual functioning concerns, barriers to seeking help, help-seeking behaviors, and provider preferences were examined to explore the types of concerns undergraduates face and the frequency with which they seek help for sexual concerns.

Descriptive Statistics

Demographic Information

There were 987 participants who began the study; however, the researcher used listwise deletion of missing data, removing cases if data were not present on all sections of the questionnaire. The majority of cases that were deleted following this initial exploration of the data were deleted because they had entered the survey but not completed any of the questionnaires. Over 600 cases were deleted for this reason. Additionally, cases were excluded if participants noted an age older than 23 because the desired sample was of young undergraduate students and this would have represented a confounding variable. A total of 13 cases were deleted for being older than age 23.

Following the missing data treatment and removing cases for participants older than the desired sample, the cleaned sample was 347 undergraduate students who represented a range of races, ethnicities, sexual orientations, sexes, and relationship structures. See Table 1 for frequency statistics of the demographic information collected in this study. The majority of the

sample was female (*n* = 235; 67.7%). Males represented 32.3% of the sample (*n* = 112). The most frequently reported sexual orientation was heterosexual (*n* = 305; 19.5%). The second most frequently reported sexual orientation was bisexual (*n* = 23; 6.6%) followed by gay or lesbian (*n* = 11; 3.2%). Most of the sample indicated that they were white non-Hispanic (*n* = 271; 78.1%) followed by white Hispanic (*n* = 20; 5.8%). Additionally, 92.5% of the sample indicated that they are very healthy, healthy, or somewhat healthy (*n* = 321). Finally, the majority of the sample indicated that they are in a committed monogamous relationship (*n* = 191; 55%). 30.5% of the sample indicated that they are single (*n* = 106). For the relationship status items that included non-monogamy, 4.1% indicated that they are currently in some form of non-monogamous relationship (*n* = 14).

Table 1
Demographic Characteristics of Participants (N = 347)

Demographic Information	n	%
Sex	347	100
Males	112	32.3
Females	235	67.7
Sexual Orientation	347	100
Bisexual	23	6.6
Heterosexual	305	87.9
Gay or Lesbian	11	3.2
Questioning	5	1.4
Transgender	1	0.3
Other	2	0.6
Year In School	347	100
First Year	75	21.6
Second Year	85	24.5
Third Year	96	27.7
Fourth Year	74	21.3
Fifth+ Year	16	4.6
Age (in years)	347	100
18	60	17.3
19	87	25.1
20	83	23.9
21	83	23.9
22	24	6.9
23	8	2.3

Race	347	100
African	1	0.3
American Indian/Alaska Native/First Nation	0	0.0
Asian/Native Hawaiian/Other Pacific Islander	17	4.9
Black or African American	7	2.0
White non-Hispanic/Latino	271	78.1
White Hispanic/Latino	20	5.8
Other Native Group	0	0.0
More Than One Race	15	4.3
Other	13	3.7
Health Status	347	100
Very Healthy	109	31.4
Healthy	174	50.1
Somewhat Healthy	38	11.0
Average	15	4.3
Somewhat Unhealthy	10	2.9
Unhealthy	6	1.3
Very Unhealthy	0	0.0
Alcohol Use	347	100
I drink more than most undergraduates	15	4.3
I drink more than some undergraduates	34	9.8
I drink about the same as most undergraduates	79	22.8
I drink less than some undergraduates	77	22.2
I drink less than most undergraduates	142	40.9
Relationship Status	347	100
Single (not in a relationship)	106	30.5
Committed monogamous relationship	191	55.0
Committed non-monogamous relationship	4	2.1
Non-committed monogamous relationship	21	6.1
Non-committed non-monogamous relationship	9	2.6
Cohabitating monogamous relationship	7	2.0
Cohabitating non-monogamous relationship	1	0.3
Married and monogamous	0	0.0
Married and non-monogamous	0	0.0
Other	8	2.3
STD Status	347	100
Have an STD	10	2.9
Does not have an STD	328	94.5
Unsure of STD status	9	2.6

Preliminary Analysis

MDI and GAD-7. The mean score on the MDI for females was 13.09 (*SD* = 11.56) whereas the mean score for males was 14.67 (*SD* = 13.26). The possible range on the MDI was 0-60 where higher scores indicate more severe depression. The actual ranges obtained were 0-60 for males and 0-55 for females. Scores between 20-24 indicate mild depression, scores between 25-29 indicate moderate depression, and scores above 30 indicate severe depression (Olsen, Jensen, Noerholm, Martiny, & Bech, 2003). The sample mean indicates that male and female participants experience less than mild depression overall. The mean score on the GAD-7 for females was 6.29 (*SD* = 5.19) whereas the mean score for males was 4.41 (*SD* = 4.63). The GAD-7 yielded a range of 0-20 for males and 0-21 for females, with higher scores indicating more severe anxiety. Scores below 4 indicate minimal anxiety, scores between 5-9 indicate mild anxiety, scores between 10-14 indicate moderate anxiety, and scores between 15-21 indicate severe anxiety (Spitzer, Kroenhe, Williams, & Lowe, 2006). The sample mean indicates that male and female participants experience mild anxiety overall. For the current sample males' mean scores on the MDI were higher than females' mean scores. Additionally, females' mean scores on the GAD-7 were higher than males' mean scores. This indicates that males endorsed more overall depression whereas women endorsed more overall anxiety.

Differences among males and females. To determine the relationship between sex and currently seeking informal help for sexual concerns or seeking informal help for sexual concerns in the future, a chi-square test of independence was conducted. The relationship between sex and currently seeking informal help for sexual concerns was not significant, $\chi^2(1, N = 347) = 1.01$, $p = .315$. The relationship between sex and seeking informal help for sexual concerns in the future was not significant, $\chi^2(1, N = 347) = 1.07$, $p = .301$. These results indicate that males and females

do not differ for current informal help-seeking status, nor do they significantly differ for seeking or not seeking informal help for sexual concerns in the future.

To determine the relationship between sex and currently seeking formal help for sexual concerns or seeking formal help for sexual concerns in the future, a chi-square test of independence was conducted. The relationship between sex and currently seeking formal help for sexual concerns was significant, $\chi^2(1, N = 347) = 6.64$, $p = .010$. The relationship between sex and seeking formal help for sexual concerns in the future was significant, $\chi^2(1, N = 347) = 10.62$, $p = .001$. These results indicate that males and females differ for currently seeking and not seeking formal help for sexual concerns as well as for seeking and not seeking formal help for sexual concerns in the future. This means that males are less likely to seek formal help for sexual concerns in the present and future than females.

To determine the relationship between sex and seeking help from any type of provider in the past, present, and future, chi-square tests of independence were conducted. The relationship between sex and seeking help from any type of provider in the past was significant, $\chi^2(1, N = 347) = 4.31$, $p = .038$. The relationship between sex and currently seeking help from any type of provider was not significant, $\chi^2(1, N = 347) = .121$, $p = .728$. The relationship between sex and seeking help from any type of provider in the future was not significant, $\chi^2(1, N = 347) = 2.182$, $p = .140$. These results indicate that males and females differ for having sought help from a variety of providers in the past meaning that females were more likely to have sought help. Males and females do not differ on their status of currently seeking help from a variety of providers, nor do they differ on their reports of seeking help from a variety of providers in the future.

Alcohol use and sexual functioning concerns. To determine if there were significant differences among drinking categories for males and scores on the IIEF, a one-way ANOVA was conducted. There was a significant difference among the five drinking categories (always, usually, sometimes, rarely, never) for males and scores on the IIEF, $F(4) = 2.901$, $p = .025$. This suggests that males who reported that alcohol was typically related to sexual functioning concerns also scored lower on the IIEF suggesting greater overall dysfunction. Given that two tests were conducted on the IIEF, a Bonferroni adjustment was utilized to reduce the risk of Type I error. The required *p* value to determine statistical significance was .025 (.05/2 = .025). Thus, the result is significant. To determine if there were significant differences among five drinking categories for females (always, usually, sometimes, rarely, never) and scores on the FSFI, a one-way ANOVA was conducted. There was no significant difference among five drinking categories for females and scores on the FSFI, $F(4) = .861$, $p = .488$. Given that two tests were conducted on the FSFI, a Bonferroni adjustment was utilized to reduce the risk of Type I error. The required *p* value to determine statistical significance was .488 (.488/2 = .244). Thus, the result is not significant. This suggests that male sexual functioning in this sample may be adversely affected by drinking behaviors.

Sex behaviors. To assess the types of sexual behaviors that undergraduates were engaging in, a sexual behaviors questionnaire was included. To determine what types of sexual behaviors undergraduates engage in, frequency analyses were conducted for each item on the sexual behaviors measure. See Table 2 for frequencies of a variety of sexual behaviors among undergraduate student participants.

Table 2
Frequencies of a Variety of Sexual Behaviors (N = 347)

Responses to Sexual Behavior Items	n	%
Lip Kissing	347	100

Often	273	78.7
Usually	25	7.2
Sometimes	18	5.2
Rarely	7	2.0
Never	45	6.9
Tongue Kissing	347	100
Often	217	62.5
Usually	55	15.9
Sometimes	32	9.2
Rarely	13	3.7
Never	28	8.1
Missing	2	.6
Caressing Partner's Genitals	347	100
Often	191	55.0
Usually	68	19.6
Sometimes	43	12.4
Rarely	9	2.6
Never	36	10.4
Having Genitals Caressed	347	100
Often	191	55.0
Usually	65	18.7
Sometimes	37	10.7
Rarely	20	5.8
Never	24	9.8
Bringing Partner to Climax with Hand	347	100
Often	77	22.2
Usually	59	17.0
Sometimes	72	20.7
Rarely	60	17.3
Never	78	22.5
Missing	1	.3
Being Brought to Climax with Partner's Hand	347	100
Often	69	19.9
Usually	59	17.0
Sometimes	68	19.6
Rarely	57	16.4
Never	93	26.8
Missing	1	.3
Bringing Partner to Climax with Mouth	347	100
Often	104	30.0
Usually	65	18.7
Sometimes	61	17.6
Rarely	47	13.5
Never	70	20.2
Being Brought to Climax with Partner's Mouth	347	100
Often	73	21.0

Usually	59	17.0
Sometimes	48	13.8
Rarely	60	17.3
Never	107	30.8
Intercourse Where Only Participant Climaxes	347	100
Often	15	4.3
Usually	25	7.2
Sometimes	57	16.4
Rarely	64	18.4
Never	185	53.3
Missing	1	.3
Intercourse Where Only Partner Climaxes	347	100
Often	66	19.0
Usually	56	16.1
Sometimes	77	22.2
Rarely	51	14.7
Never	97	28.0
Intercourse Where Neither Climax	347	100
Often	16	4.6
Usually	20	5.8
Sometimes	31	8.9
Rarely	71	20.5
Never	207	59.7
Missing	2	.6
Intercourse Where Both Climax	347	100
Often	95	27.4
Usually	77	22.2
Sometimes	63	18.2
Rarely	34	9.8
Never	78	22.5
Anal Intercourse	347	100
Often	9	2.6
Usually	10	2.9
Sometimes	20	5.8
Rarely	28	8.1
Never	280	80.7

Sexuality Measures and Associations with Various Mental Health Measures

To determine if the FSFI, a measure of female sexual dysfunction, the SQOLF, a measure of female sexual quality of life, the MDI, a measure of depression, the GAD-7, a measure of anxiety, and the ATSPPHS-SF, a measure of attitudes toward help seeking were related, a series

of Pearson correlational analyses were conducted. The FSFI and SQOLF were significantly correlated, as well as the FSFI and the MDI. The SQOLF was significantly correlated with the MDI and GAD-7. See Table 3 for means and correlations for these measures. Correlational analyses revealed that scores on the FSFI are related to scores on the SQOLF (r = .620, p = .000), which suggests that female participants who reported fewer overall sexual functioning concerns also reported better overall quality of sexual life. Scores on the FSFI were also significantly inversely correlated to scores on the MDI (r = -.177, p = .007), but not the GAD-7 (r = -.117, p = .075). This suggests that female participants who reported fewer overall sexual functioning concerns reported less severe depression, but that female participants' sexual concerns were not significantly related to severity of anxiety. Scores on the SQOLF were significantly inversely correlated to scores on the MDI (r = -.436, p = .000) and the GAD-7 (r = -.353, p = .000). This indicates that female participants who reported better overall quality of sexual life reported less severe depression and less severe anxiety, respectively. Scores on the ATSPPHS-SF were unrelated to scores on the FSFI (r = .110, p = .097), the SQOLF (r = .092, p = .170), the MDI (r = .042, p = .530), and the GAD-7 (r = .120, p = .069). This means that attitudes toward help-seeking are not related to depression, anxiety, sexual quality of life, or sexual dysfunction for females.

Table 3
Correlations: Female Data

Pearson Correlation					
	SQOLF	FSFI	MDI	GAD-7	ATSPPHS-SF
SQOLF	-	.620**	-.436**	-.353**	.092
FSFI	.620**	-	-.177**	-.117	.110
MDI	-.436**	-.177**	-	.751**	.042
GAD-7	-.353**	-.117	.751**	-	.120
ATSPPHS-SF	.092	.110	.042	.120	-

Note: ** p < .01 (2-tailed)

To determine if the IIEF and IPE, measures of male sexual dysfunction, the SQOLM, a measure of male sexual quality of life, the MDI, a measure of depression, the GAD-7, a measure of anxiety, and the ATSPPHS-SF, a measure of attitudes toward help seeking were related, correlational analyses were conducted. The IIEF was significantly correlated to the SQOLM, the IPE, and the MDI. The IPE was significantly correlated to the MDI and the SQOLM. The SQOLM and the MDI were significantly correlated, as well as the SQOLM and the GAD-7. See Table 4 for means and correlations for these measures. Correlational analyses revealed that scores on the IIEF are related to scores on the SQOLM (r = .405, p = .000), which indicates that male participants who reported lower overall sexual functioning concerns including erectile functioning also reported better overall quality of sexual life. Scores on the IIEF were also significantly inversely correlated to scores on the MDI (r = -300, p = .001), but not the GAD-7 (r = -.159, p = .095), which indicates that male participants who reported lower overall sexual functioning concerns including erectile functioning reported less severe depression, but that male participants who reported lower overall sexual functioning concerns including erectile functioning was unrelated to severity of anxiety. Scores on the IPE were significantly correlated to scores on the SQOLM (r = .369, p = .000), the IIEF (r = .879, p = .000), and the MDI (r = -.228, p = .015), but not the GAD-7 (r = -.106, p = .266). These results indicate that male participants who reported lower overall concern about ejaculatory control also reported better overall quality of sexual life, fewer concerns about erectile functioning, and less severe depression; however, participants who reported fewer concerns about ejaculatory control was unrelated to severity of anxiety. Scores on the SQOLM were significantly inversely correlated to scores on the MDI (r = -.550, p = .000) and the GAD-7 (r = -.444, p = .000), which indicates that male participants who reported better overall quality of sexual life reported less severe

depression and less severe anxiety, respectively. Scores on the ATSPPHS-SF were unrelated to scores on the SQOLM (r = .014, p = .886), the IIEF (r = .117, p = .216), the IPE (r = -.129, p = .174), the MDI (r = .087, p = .362), and the GAD-7 (r = .179, p = .059). This means that that attitudes toward seeking professional psychological help are unrelated to sexual dysfunction, sexual quality of life, depression, and anxiety for males.

Table 4
Correlations: Male Data

Pearson Correlation						
	SQOLM	IIEF	IPE	MDI	GAD-7	ATSPPHS-SF
SQOLM	-	.405**	.369**	-.550**	-.444**	.014
IIEF	.405**	-	.879**	-.300**	-.159	.117
IPE	.369**	.879**	-	-.228*	-.106	-.129
MDI	-.550**	-.300**	-.228*	-	.483**	.087
GAD-7	-.444**	-.159	-.106	.483**	-	.170
ATSPPHS-SF	.014	.117	-.129	.087	.170	-

Note: ** p < .01 (2-tailed) * p < .05 (2-tailed)

Occurrence of Sexual Functioning Concerns

Female sexual functioning concerns. To determine what types of sexual functioning concerns undergraduate females report, frequency analyses were conducted for the FSFI. The possible range on the FSFI was 2-95, with higher scores indicating fewer concerns about sexual functioning or better overall functioning. The mean in this sample was 67.31 (SD = 24.90; range 2-95). One study found a mean score of 45.4 (SD = 24) on the FSFI for a clinical sample of women (Ter Kulie, Brauer, & Laan, 2006). This means that the current sample experiences some overall sexual functioning concerns, but scores are higher overall than that of a clinical sample indicating better overall functioning. The FSFI is comprised of six subscales, which include desire, arousal, lubrication, orgasm, satisfaction and pain. The possible range for the desire subscale was 2-10 with higher scores indicating more overall sexual desire. The mean in this sample was 6.79 (SD = 1.79; range 2-10). The possible range for the arousal subscale was 0-20

with higher scores indicating more overall sexual arousal. The mean in this sample was 14.49 (*SD* = 6.44; range 0-20). The possible range for the lubrication subscale was 0-20 with higher scores indicating fewer difficulties lubricating during sexual activity. The mean in this sample was 15.12 (*SD* = 6.69; range 0-20). The possible range for the orgasm subscale was 0-15 with higher scores indicating fewer difficulties in achieving orgasm. The mean in this sample was 8.96 (*SD* = 5.22; range 0-15). The possible range for the satisfaction subscale was 2-15 with higher scores indicating greater overall satisfaction with ones sexual life. The mean in this sample was 11.73 (*SD* = 3.55; range 2-15). The possible range for the pain subscale was 0-15 with higher scores indicating fewer difficulties with experiencing pain during sexual encounters. The mean in this sample was 10.43 (*SD* = 5.36; range 0-15). This means that the current sample has more sexual functioning concerns in the area of arousal than lubrication. Additionally, the sample appears to have more concerns over orgasmic functioning than satisfaction or pain.

Male sexual functioning concerns. To determine what types of sexual functioning concerns undergraduate males report, frequency analyses were conducted for the IPE and the IIEF. The possible range on the IIEF was 5-75 with higher scores indicating fewer concerns about sexual functioning or better overall functioning. The mean in this sample was 55.78 (*SD* = 19.81; range 5-75). The IIEF is comprised of five subscales, which include erectile function, orgasmic function, sexual desire, intercourse satisfaction, and overall satisfaction. The possible range for the erectile function subscale was 1-30 with higher scores indicating lower overall dysfunction. The mean in this sample was 24.15 (*SD* = 9.53; range 2-30). The sample mean indicates that participants experience mild to no dysfunction overall with erectile functioning. The possible range for the orgasmic function subscale was 0-10 with higher scores indicating lower overall orgasmic dysfunction. The mean in this sample was 8.04 (*SD* = 3.36; range 0-10).

The sample mean indicates that for orgasmic functioning, participants experience mild to no dysfunction overall. The possible range for the sexual desire subscale was 2-10 with higher scores indicating lower overall dysfunction with sexual desire. The mean in this sample was 7.60 (*SD* = 1.73; range 2-10). The sample mean indicates that for dysfunction of sexual desire, participants experience mild dysfunction overall. The possible range for the intercourse satisfaction subscale was 0-15 with higher scores indicating higher overall satisfaction with sexual intercourse. The mean in this sample was 9.19 (*SD* = 5.13; range 0-15). The sample mean indicates that for satisfaction with sexual intercourse, participants experience mild to moderate dysfunction overall. The possible range for the overall satisfaction subscale was 2-10 with higher scores indicating greater overall satisfaction with ones sexual life. The mean in this sample was 7.40 (*SD* = 2.36; range 2-10). The sample mean indicates that for satisfaction with ones sexual life, participants experience mild to moderate dysfunction. Overall it appears that participants experienced greater concerns in the areas of sexual desire and satisfaction with their overall sexual life.

The possible range on the IPE was 2-50, with higher scores indicating more ejaculatory control, greater overall satisfaction with sexual life, and lower distress. The mean in this sample was 32.49 (*SD* = 15.63; range 1-50). The IPE is comprised of three subscales, which include sexual satisfaction, ejaculatory control, and distress. The possible range for the sexual satisfaction subscale was 2-20 with higher scores indicating greater overall sexual satisfaction. The mean in this sample was 14.49 (*SD* = 6.43; range 1-20). The possible range for the ejaculatory control subscale was 0-20 with higher scores indicating greater overall ejaculatory control. The mean in this sample was 11.99 (*SD* = 6.73; range 0-20). The possible range for the distress subscale was 0-10 with higher scores indicating lower overall distress with sexual

activity. The mean in this sample was 6.00 (*SD* = 3.58; range 0-10). It appears that overall, participants experience greater concerns in the area of ejaculatory control than in overall sexual satisfaction.

Taken together, it is clear that male and female undergraduates experience a range of concerns related to sexual functioning. For women, arousal and orgasm concerns were more common than concerns about lubrication, satisfaction, or pain. Additionally, undergraduate women endorsed lower overall sexual concerns than women in a clinical sample. For men, sexual desire, satisfaction with overall sexual life, and ejaculatory control were the more common concerns endorsed. Sexual satisfaction was not as common of a concern for men than the aforementioned concerns. Mean scores for sexual functioning concerns tended to fall in the mild to moderate categories overall. Thus, sexual functioning concerns are present in the undergraduate sample despite their age, but may be lower overall than sexual functioning concerns present in a clinical sample.

Types of Help Sources Preferred by Undergraduates for Sexual Functioning Concerns

To determine if participants who endorsed greater overall sexual functioning concerns, and lower overall quality of sexual life were more likely to seek formal and informal help, independent samples *t*-tests were conducted. Additionally, to determine if participants who indicated more negative attitudes toward seeking professional help were less likely to seek formal help, an independent samples *t*-test was conducted. Thus, *t*-tests were conducted to determine if the ATSPPHS-SF, IIEF, IPE, SQOLM, SQOLF, and FSFI varied based on seeking or not seeking formal and informal help. See Table 5 for frequency statistics of the participants who have ever sought help from any informal and formal sources in the past, present, and future as well as participants who have ever sought help from specific providers in the past, present,

and future. For the ATSPPHS-SF, there was no significant difference in the scores for seeking formal help currently (M = 16.50, SD = 3.74) and not seeking formal help currently (M = 14.36, SD = 5.63); $t(111) = -1.06$, $p = .294$. Additionally, there was no significant difference in scores on the ATSPPHS-SF for seeking informal help currently (M = 15.97, SD = 4.77) and not seeking informal help currently (M = 13.89, SD = 5.74); $t(111) = -1.86$, $p = .07$. The results indicate that there are no significant differences in scores on the ATSPPHS-SF for participants who are currently seeking or not seeking help from formal and informal help sources. This means that participants who are currently seeking help from formal or informal help sources have a variety of attitudes toward seeking professional help.

For the IIEF, the measure of erectile function, there were significant differences in the scores for seeking formal help currently (M = 63.13, SD = 5.41) and not seeking formal help currently (M = 55.22, SD = 20.40); $t(28) = -2.86$, $p = .008$. Additionally, there was no significant difference in the scores on the IIEF for seeking informal help currently (M = 55.88, SD = 17.57) and not seeking informal help currently (M = 55.73, SD = 20.80); $t(111) = -.036$, $p = .971$. The results indicate that there are significant differences in scores on the IIEF for participants who are currently seeking or not seeking formal help; however, there are no significant differences in scores on the IIEF for participants who are currently seeking or not seeking help from informal help sources. This means that participants experience a range of concerns related to erectile functioning, orgasmic function, sexual desire, intercourse satisfaction, and overall satisfaction regardless of whether they are seeking or not seeking informal help. However, participants who are currently seeking formal help scored higher on the IIEF indicating that they experience fewer sexual functioning concerns. This is contrary to what one may think, but there are a few reasons why this could be the case. First, it may be that males

who are seeking formal help are reporting fewer concerns because they are receiving help. Also, given that a small number of males in the current sample were seeking formal help, it may be that the mean score on the IIEF for males who were not seeking formal help was more sensitive to a range of scores on the IIEF. There may also be some other reason for this discrepancy unrelated to the two aforementioned explanations.

For the IPE, the measure of this, there was a significant difference in the scores for seeking formal help currently (M = 40.75, SD = 4.68) and not seeking formal help currently (M = 31.86, SD = 16.00); $t(24) = -3.91$, $p = .001$. Additionally, there was no significant difference in the scores on the IPE for seeking informal help currently (M = 33.15, SD = 14.10) and not seeking informal help currently (M = 32.20, SD = 16.32); $t(111) = -.293$, $p = .770$. The results indicate that there are significant differences in scores on the IPE for participants who are currently seeking or not seeking formal help; however, there are no significant differences in scores on the IPE for participants who are currently seeking or not seeking help from informal help sources. This means that participants experience a range of concerns related to ejaculatory control, overall sexual satisfaction, and distress regardless of whether they are seeking or not seeking informal help. Additionally, participants who are currently seeking formal help scored higher on the IPE indicating that they experience fewer sexual functioning concerns. Similarly to scores on the IIEF, this discrepancy may be explained by the fact that these individuals are seeking help for their concerns or because the mean of scores on the IPE is more sensitive to a range in scores for males who are not seeking formal help.

For the Sexual Quality of Life Questionnaire-Male, there was a significant difference in the scores for seeking formal help currently (M = 36.13, SD = 17.41) and not seeking formal help currently (M = 53.47, SD = 13.09); $t(111) = 3.528$, $p = .001$. Additionally, there was a

significant difference in the scores on the SQOLM for seeking informal help currently (M = 46.00, SD = 15.77) and not seeking informal help currently (M = 54.92, SD = 12.44); $t(52)$ = 2.931, p = .005. The results indicate that there are significant differences in scores on the SQOLM for participants who are currently seeking or not seeking help from formal and informal sources. This means that participants who indicated that they had a better overall sexual quality of life were less likely to seek help from informal and formal sources.

For the Sexual Quality of Life Questionnaire-Female, there was no significant difference in the scores for seeking formal help currently (M = 90.36, SD = 15.07) and not seeking formal help currently (M = 88.88, SD = 18.02); $t(224)$ = -.478, p = .633. For the SQOLF, there was no significant difference in the scores for seeking informal help currently (M = 87.57, SD = 16.23) and not seeking informal help currently (M = 89.98, SD = 18.18); $t(224)$ = .986, p = .325.The results indicate that there are not significant differences in scores on the SQOLF for participants who are currently seeking or not seeking help from formal and informal sources. This means that participants who were seeking informal and formal help and not seeking informal and formal help experienced a range of sexual quality of life.

For the FSFI, the measure of female sexual functioning, there was no significant difference in the scores for seeking formal help currently (M = 67.71, SD = 24.48) and not seeking formal help currently (M = 67.23, SD = 25.05); $t(232)$ = -.112, p = .911. For the FSFI, there was no significant difference in the scores for seeking informal help currently (M = 67.65, SD = 22.72) and not seeking informal help currently (M = 67.13, SD = 26.05); $t(232)$ = -.153, p = .879.The results indicate that there are not significant differences in scores on the FSFI for participants who are currently seeking or not seeking help from formal and informal sources. This means that female participants experienced a range of concerns related to orgasm, pain,

arousal, lubrication, desire, and satisfaction regardless of whether or not they were seeking informal or formal help.

Table 5
Frequencies of Help-Seeking from Help Sources and Providers (N = 347)

Help-Seeking From Formal and Informal Sources and Specific Providers	n	%
Sought Help In Past From Any Help Source	347	100
Yes	188	54.2
No	159	45.8
Sought Help In Past From Any Type of Provider	347	100
Yes	189	54.5
No	158	45.5
Seeking Help Currently From Any Help Source	347	100
Yes	239	68.9
No	108	31.1
Seeking Help Currently From Any Type of Provider	347	100
Yes	206	59.4
No	141	40.6
Consider Seeking Help In The Future From Any Help Source	347	100
Yes	303	100
No	44	55.0
Consider Seeking Help In The Future From Any Type of Provider	347	100
Yes	259	74.6
No	88	25.4

Types of Providers Utilized by Undergraduates for Sexual Functioning Concerns

For the purposes of the current study, Marriage and Family Therapists (MFT), Sex Counselors, and Sex Therapists were of particular interest to assess the utilization of these services in an undergraduate sample. See Table 6 for frequency statistics of the participants who have ever used MFT, Sex Counselors, or Sex Therapists in the past and currently for sexual functioning concerns as well as those who would consider utilizing these providers in the future for sexual concerns. To determine whether scores on the IIEF, IPE, SQOLM, SQOLF, and FSFI varied based on seeking or not seeking help from Sex Therapists and Sex Counselors,

independent samples t-tests were conducted. To determine whether scores on the IIEF, IPE, SQOLM, SQOLF, and FSFI varied based on seeking or not seeking help from any type of provider, independent samples *t*-tests were conducted.

There was a significant difference in the scores on the Index of Premature Ejaculation for currently seeking help from sex counselors and sex therapists (M = 39.80, SD = 3.27) and not currently seeking help from sex therapists and sex counselors (M = 32.15, SD = 15.90); $t(17) = -3.615$, $p = .002$. For the IIEF, there was not a significant difference in the scores for currently seeking help from sex counselors and sex therapists (M = 62.80, SD = 6.14) and not currently seeking help from sex therapists and sex counselors (M = 55.45, SD = 20.17); $t(9) = -2.185$, $p = .057$. The results indicate that there are significant differences in scores on the IPE for participants who are and are not currently seeking help from sex therapists and sex counselors; however, there are no significant differences in scores on the IIEF for participants who are and are not currently seeking help from sex therapists and sex counselors. This means that males who were currently seeking help from a sex therapist or sex counselor scored higher on the IPE indicating fewer sexual concerns. However, scores on the IIEF did not significantly vary by current help-seeking status from a sex therapist or sex counselor.

For the SQOLM, there was a significant difference in the scores for currently seeking help from sex counselors and sex therapists (M = 24.20, SD = 5.07) and not currently seeking help from sex therapists and sex counselors (M = 53.54, SD = 12.96); $t(7) = 11.34$, $p = .000$. Additionally, there was no significant difference in the scores on the SQOLF for currently seeking help from sex counselors and sex therapists (M = 86.00, SD = n/a) and not currently seeking help from sex therapists and sex counselors (M = 89.15, SD = 17.56); $t(224) = .179$, $p = .858$. The results indicate that there are significant differences in scores on the SQOLM for

participants who are and are not currently seeking help from sex therapists and sex counselors; however, there are no significant differences in scores on the SQOLF for participants who are and are not currently seeking help from sex therapists and sex counselors. This means that males who were currently seeking help from a sex counselor or sex therapist scored significantly lower on the SQOLM indicating lower overall quality of sexual life. Females' scores on the SQOLF did not vary significantly by help-seeking status from a sex therapist or sex counselor.

For the FSFI, there was no significant difference in the scores for currently seeking help from sex counselors and sex therapists (M = 72.00, SD = n/a) and not currently seeking help from sex therapists and sex counselors (M = 67.29, SD = 24.95); $t(232)$ = -.188, p = .851. The results indicate that there are no significant differences in scores on the FSFI for participants who are and are not currently seeking help from sex therapists and sex counselors.

Table 6
Frequencies of Specific Provider Preferences (N = 347)

Specific Provider Preferences	n	%
Sought Help From an MFT in the Past	347	100
Yes	12	3.5
No	335	96.5
Sought Help From a Sex Counselor in the Past	347	100
Yes	6	1.7
No	341	98.3
Sought Help From a Sex Therapist in the Past	347	100
Yes	4	1.2
No	343	98.8
Seeking Help Currently From an MFT	347	100
Yes	3	.9
No	344	99.1
Seeking Help Currently From a Sex Counselor	347	100
Yes	5	1.4
No	342	98.6
Seeking Help Currently From a Sex Therapist	347	100
Yes	4	1.2
No	343	98.8
Consider Seeking Help in the Future from an MFT	347	100
Yes	116	33.4
No	231	66.6

Consider Seeking Help in the Future from a Sex Counselor	347	100
Yes	130	37.5
No	217	62.5
Consider Seeking Help in the Future from a Sex Therapist	347	100
Yes	138	39.8
No	209	60.2

Barriers to Seeking Help for Sexual Functioning Concerns

To determine the types of barriers to seeking help for sexual functioning concerns endorsed by participants, frequency analyses were conducted. See Table 7 for frequencies of barrier items endorsed by participants. To determine if participants who endorsed more barriers to seeking help were less likely to have sought help in the past, be currently seeking help, or consider seeking help in the future, independent samples *t*-tests were conducted. For males, there was no significant difference in the scores for seeking any type of help in the past (M = 55.77, SD = 14.15), present (M = 59.35, SD = 17.96), or future (M = 58.37, SD = 17.80) and not seeking any type of help in the past (M = 61.59, SD = 19.43); $t(109) = -1.824$, $p = .071$, present (M = 56.06, SD = 14.02); $t(109) = .948$, $p = .345$, or future (M = 58.21, SD = 11.65); $t(109) = .037$, $p = .970$. For females, there was no significant difference in the scores for seeking any type of help in the present (M = 54.74, SD = 17.51) or future (M = 55.75, SD = 16.41) and not seeking any type of help in the present (M = 56.73, SD = 14.29); $t(232) = -.853$, $p = .395$, or future (M = 52.20, SD = 17.74); $t(232) = 1.014$, $p = .312$. For females, there was a significant difference in the scores for seeking any type of help in the past (M = 52.58, SD = 14.53) and not seeking any type of help in the past (M = 58.52, SD = 18.14); $t(232) = -2.777$, $p = .006$. The results indicate that there are not significant differences in scores on the barriers measure for male participants for seeking any type of help in the past, present, or future. The results indicate that there are no significant differences in scores on the barriers measure for female participants

for seeking any type of help in the present and future; however, there was a significant difference for females in scores on the barriers measure for seeking any type of help in the past. This means that for males and females, greater agreement with a range of barriers to seeking help did not make them more or less likely to be currently seeking help in the present, or consider seeking help in the future. For males, regardless of the barriers endorsed, they were no more or less likely to have sought help in the past, but for females, endorsing greater barriers meant that they were less likely to have sought help in the past.

Table 7
Frequencies of Variety of Barriers to Seeking Help For Sexual Concerns (N = 347)

Barriers to Seeking Help For Sexual Concerns	n	%
Personal Weakness or Failure	347	100
Strongly Disagree	83	23.9
Disagree	117	33.7
Somewhat Disagree	56	16.1
Somewhat Agree	64	18.4
Agree	15	4.3
Strongly Agree	10	2.9
Missing	2	.6
Preference to Deal with Problems on Own	347	100
Strongly Disagree	27	7.8
Disagree	51	14.7
Somewhat Disagree	48	13.8
Somewhat Agree	99	28.5
Agree	75	21.6
Strongly Agree	45	13.0
Missing	2	.6
Negative Past Experience with Mental Health Professional	347	100
Strongly Disagree	177	51.0
Disagree	86	24.8
Somewhat Disagree	37	10.7
Somewhat Agree	24	6.9
Agree	9	2.6
Strongly Agree	11	3.2
Missing	3	.9
Preference to Talk to Family and Friends	347	100
Strongly Disagree	55	15.9

Disagree	49	14.1
Somewhat Disagree	66	19.0
Somewhat Agree	82	23.6
Agree	62	17.9
Strongly Agree	31	8.9
Missing	2	.6
Being Embarrassed	347	100
Strongly Disagree	56	16.1
Disagree	76	21.9
Somewhat Disagree	55	15.9
Somewhat Agree	98	28.2
Agree	33	9.5
Strongly Agree	27	7.8
Missing	2	.6
Fear of Being Judged or Stereotyped	347	100
Strongly Disagree	88	25.4
Disagree	90	25.9
Somewhat Disagree	52	15.0
Somewhat Agree	72	20.7
Agree	29	8.4
Strongly Agree	14	4.0
Missing	2	.6
Not Believing There is a Problem/Not Wanting to Change	347	100
Strongly Disagree	43	12.4
Disagree	60	17.3
Somewhat Disagree	74	21.3
Somewhat Agree	61	17.6
Agree	64	18.4
Strongly Agree	42	12.1
Missing	3	.9
Lack of Transportation	347	100
Strongly Disagree	168	48.4
Disagree	90	25.9
Somewhat Disagree	31	8.9
Somewhat Agree	31	8.9
Agree	20	5.8
Strongly Agree	5	1.4
Missing	2	.6
Therapy is Too Expensive	347	100
Strongly Disagree	48	13.8
Disagree	61	17.6
Somewhat Disagree	55	15.9
Somewhat Agree	92	26.5
Agree	49	14.1
Strongly Agree	40	11.5

Missing	2	.6
Insurance Does Not Cover Therapy	347	100
Strongly Disagree	79	22.8
Disagree	69	19.9
Somewhat Disagree	57	16.4
Somewhat Agree	71	20.5
Agree	35	10.1
Strongly Agree	32	9.2
Missing	4	1.2
Lack of Time for Therapy	347	100
Strongly Disagree	55	15.9
Disagree	74	21.3
Somewhat Disagree	66	19.0
Somewhat Agree	84	24.2
Agree	41	11.8
Strongly Agree	23	6.6
Missing	4	1.2
Lack of Knowledge of Providers	347	100
Strongly Disagree	66	19.0
Disagree	64	18.4
Somewhat Disagree	51	14.7
Somewhat Agree	97	28.0
Agree	49	14.1
Strongly Agree	18	5.2
Missing	2	.6

To determine if participants who endorsed more barriers to seeking help were less likely to have sought help from any type of formal provider in the past, present, or potential future, independent samples *t*-tests were conducted. For males, there was no significant difference in the scores for seeking help from any type of provider in the past (M = 56.75, SD = 18.40), present (M = 57.02, SD = 16.73), or future (M = 56.54, SD = 16.69) and not seeking help from any type of provider in the past (M = 59.70, SD = 15.46); $t(109) = -.920$, $p = .360$, present (M = 60.15, SD = 17.05); $t(109) = -.967$, $p = .336$, or future (M = 62.61, SD = 16.73); $t(109) = -1.749$, $p = .083$. For females, there was no significant difference in the scores for seeking help from any type of provider in the past (M = 53.70, SD = 17.56), present (M = 55.13, SD = 17.67), or future (M = 54.22, SD = 16.69) and not seeking help from any type of provider in the past (M = 57.69,

SD = 14.83); *t*(232) = -1.830, *p* = .068, present (*M* = 55.73, *SD* = 14.84); *t*(232) = -.274, *p* = .785, or future (*M* = 59.20, *SD* = 15.66); *t*(232) = -1.951, *p* = .052. The results indicate that, for male and female participants, there are not significant differences in scores on the barriers measure for seeking help from any type of provider in the past, present, or future.

To determine if scores on the measure that assessed barriers to seeking help for sexual concerns varied based on sex, an independent samples t-test was conducted. For males and females, there was no significant difference in the scores on the barriers measure and being male (*M* = 58.21, *SD* = 16.88) and being female (*M* = 55.45, *SD* = 16.56); *t*(343) = 1.44, *p* = .152. The results indicate that there are not significant differences in scores on the barriers measure for males and females. This means that men were not significantly more likely than women to endorse more barriers to seeking help for sexual concerns nor were women significantly more likely than men to endorse more barriers to seeking help for sexual concerns.

Attitudes Toward Seeking Help and Barriers

To determine the relationship between attitudes toward seeking professional help and barriers to seeking help, correlational analyses were conducted. Attitudes toward seeking professional psychological help was significantly correlated to participants endorsed barriers to seeking help (*r* = -.366, *p* = .000). This means that for participants who reported that they have more positive attitudes toward mental health professionals also endorsed less agreement with a range of barriers to seeking help for sexual concerns. To determine if scores on the ATSPPH-SF varied based on sex, an independent samples t-test was conducted. For males and females, there was a significant difference in the scores on the ATSPPH-SF and being male (*M* = 14.55, *SD* = 5.54) and being female (*M* = 17.44, *SD* = 5.81); *t*(341) = -4.377, *p* = .000. The results indicate

that there are significant differences in scores on ATSPPH-SF for males and females. This means that females had more positive attitudes to seeking professional help than males.

CHAPTER 5: DISCUSSION

The purposes of the current study were to determine the types of sexual functioning concerns facing a sample of undergraduate students, to determine if they sought help in the past, present, and potential future for sexual concerns, to identify the most common barriers to seeking professional help endorsed by undergraduate students, and to determine the type of providers most preferred among undergraduate students. The current study supports the findings of previous research, which suggests that despite the occurrence of sexual functioning concerns, few people have sought help in the past or are currently seeking help (Cohen, 2006; Gulliver, Griffiths, & Christensen, 2010; Sobczak, 2009b). Interestingly, the majority of participants reported that they would consider seeking help in the future from informal and formal sources as well as from a range of providers. However, the majority of participants indicated that they would not seek help for sexual concerns from a marriage and family therapist, a sex counselor, or a sex therapist in the future despite the fact that these providers specialize in treatment of sexual functioning concerns. Additionally, the current study provided preliminary evidence that a sample of undergraduate females and males experience sexual functioning concerns despite being overall healthy and young. According to the data, women were more likely to have concerns about arousal and pain than about lubrication and sexual satisfaction. For men, the data suggests that participants were more likely to have concerns about sexual desire, ejaculatory control, and satisfaction with overall sexual life than with erectile functioning or satisfaction with intercourse. The data may reflect that participants' experienced concerns are normal for his or her stage of sexual development.

Results indicated that for women, better overall sexual quality of life was significantly related to having lower levels of sexual functioning concerns. Results were similar for men,

which suggests that better overall sexual quality of life was significantly related to having lower levels of sexual functioning concerns. Additionally, for both males and females, more severe depression was significantly related to having higher levels of sexual functioning concerns and a lower overall sexual quality of life. However, more severe anxiety for males and females was significantly related to lower overall sexual quality of life, but not significantly related to higher levels of sexual functioning concerns. The data from the current study supports findings from previous studies that have suggested a link between depressive symptoms and sexual dysfunction (Shifren, Johannes, Monz, Russo, Bennett, & Rosen, 2009). The data also suggests that there is an association between participants' level of concern with sexual functioning and his or her perception of the overall quality of sexual life.

For purposes of the current study, results for help-seeking were analyzed based on formal and informal help sources. Formal help sources included Planned Parenthood and sex educators, mental health professionals, gynecologists, and primary care physicians. Informal help sources included the internet, newspapers, magazines, television, informational pamphlets, help-lines, friends, family members, members of clergy or church officials, mentors, teachers, and peer educators. Males who endorsed greater sexual functioning concerns were also significantly more likely to be seeking formal help currently; however, males who sought help from informal sources were not more likely to be experiencing greater sexual functioning concerns. Better overall quality of sexual life for males meant that they were significantly less likely to have sought help from informal or formal sources. Females with a better overall quality of sexual life were no more likely to seek formal or informal help than females who had a lower overall quality of sexual life. Females were also not more likely to seek formal or informal help for higher levels of sexual functioning concerns.

Results examining attitudes toward seeking help and variation in seeking formal and informal help indicate that participants' positive attitudes toward seeking help did not make them more likely to seek help for sexual functioning concerns. This means that regardless of participants' attitudes toward seeking professional help, frequency of seeking help for sexual concerns was low for the current sample. The fact that attitude is not a significant barrier for seeking help for the current sample is important. Negative attitudes toward seeking help has typically been linked with underutilization of services (Vogel & Wester, 2003). However, for the current sample, attitude is unrelated to seeking informal and formal help. This suggests that attitude toward seeking help was not a useful predictor of lack of help-seeking. Additionally, females reported more positive attitudes toward seeking professional help than males in the current sample. This is similar to prior research that indicates that males report more negative attitudes toward help-seeking than women (Morrell & Metzl, 2006; Nam, Chu, Lee, Kim, & Lee, 2010; Tsan, Day, Schwartz, Kimbrel, & 2011).

Barriers to Seeking Help for Sexual Functioning Concerns

Participants identified a variety of barriers to seeking help for sexual functioning concerns. The majority of participants indicated that lack of transportation and negative past experiences with mental health professionals were not barriers to seeking help for sexual concerns. This is contrary to previous research that found lack of transportation and negative past experiences to be prevalent barriers to seeking formal help (Gulliver, Griffith, & Christensen, 2010; Morrell & Metzl, 2006). However, the majority of participants agree that a barrier to seeking help is that it is expensive and that they would prefer to talk to friends and family. Given that the participant sample was undergraduate students, it seems appropriate that they would not consider lack of transportation or negative past experience to be barriers to seeking treatment.

Due to the fact that the participants at the sample institution had access to mental and physical health facilities on campus, they may have been less likely to consider transportation a barrier. Also, participants may have been less likely to have had a negative past experience with mental health services since the majority of the sample had not previously sought professional help for any reason. Given that undergraduate students tend to have more income restrictions, it also seems appropriate that they would consider therapy to be too expensive. Interestingly, most participants did not identify being embarrassed as being a barrier to seeking help. Additionally, most participants disagreed that seeking help was a sign of personal failure or weakness, nor did they believe that mental health professionals would judge or stereotype them. These findings diverge from findings of previous researchers who suggest that personal failure or weakness has been identified as a barrier to seeking help (Vogel, Heimerdinger-Edwards, Hammer, & Hubbard, 2011), as well as worry that mental health professionals would be judgmental or stereotype clients (Morrell & Metzl, 2006). Overall, participants in the current study demonstrated a preference for self-reliance instead of seeking help for sexual concerns.

Results indicated that endorsing more barriers to seeking help for sexual concerns did not make males less likely to seek treatment in the past, present, or consider seeking help in the future. Results indicate that endorsing more barriers to seeking help for sexual concerns did not make females less likely to seek treatment in the present or consider seeking help in the future. However, females who endorsed more barriers to seeking help for sexual concerns were significantly less likely to have sought help in the past. Additionally, results indicate that endorsing more barriers to seeking help for sexual concerns did not make males or females less likely to seek help from a variety of providers in the past or present, or consider seeking help from a variety of providers in the future. For the current sample, males did not differ from

females in their endorsement of barriers to seeking help for sexual functioning concerns. However, males and females who reported having more positive attitudes toward seeking help were also less likely to agree with a range of barriers to seeking help.

Provider Preferences

The current study focused primarily on participants' preferences for three specific providers. They are marriage and family therapists, sex counselors, and sex therapists. Males who had more sexual concerns in the area of premature ejaculation were more likely to be seeking help from sex therapists and sex counselors currently; however males who had more sexual concerns in the area of erectile functioning were not more likely to be seeking help from sex therapists and sex counselors currently. Males in the sample who are currently seeking help from sex counselors and sex therapists are scored lower for overall quality of sexual life suggesting that having a lower overall quality of sexual life is related to seeking help for sexual concerns. Females in the sample were not more likely to seek help from a sex counselor or therapist regardless of if they had greater sexual dysfunction or a lower overall quality of sexual life.

The majority of the sample indicated that they had never sought help from a marriage and family therapist, sex counselor, or sex therapist in the past. An even smaller percent of the sample indicated that they are currently seeking help from one of these providers. Interestingly, about a third of participants indicated that they would seek help from a marriage and family therapist in the future, while slightly more than a third of participants indicated that they would seek help from a sex counselor and sex therapist in the future. This suggests that individuals would prefer to seek help from a sex counselor or sex therapist over a marriage and family therapist for sexual concerns in the future. This preference may reflect individualistic thinking

present in the current sample of undergraduate students that a sexual problem is that of the individual who has the problem. However, research demonstrates that problems with sexual dysfunction are a relational issues and treatment involving the individual with the problem as well as his or her partner(s) is most effective in treating sexual dysfunction (Leiblum, 2007; Woody, 1992).

Males and Female Differences

There are several differences between males and females that are important to note in the current sample. Males were not more likely than females to seek informal help in the present or to consider seeking informal help in the future. However, females were significantly more likely to be seeking formal help currently than males. Males were less likely than females to report that they would consider seeking help in the future from formal sources. Additionally, females were more likely than males to have sought help from a variety of providers in the past, yet females were not more likely to be currently seeking help from a variety of providers currently nor were they more likely to consider seeking help from a variety of providers in the future. Overall, the findings of the current study suggest that there are not as many differences between males and females in seeking help as other studies have found in the past. The major difference found between males and females was that males were less likely to be currently seeking formal help and were less likely to consider seeking formal help in the future. This finding seems to be consistent with other studies on help-seeking.

Implications and Summary

The current study provides a more in depth understanding of the specific types of sexual functioning concerns faced by a sample of undergraduate students. The current findings suggest that despite being a healthy sample overall, undergraduate students experience some sexual

concerns. Unfortunately, the current study continues to support findings of previous studies that similarly conclude that seeking professional help for sexual concerns is largely uncommon (Shifren, Johannes, Monz, Russo, Bennett, & Rosen, 2009). Particularly for marriage and family therapists, sex counselors, and sex educators, who specialize in the treatment of sexual functioning concerns, less than half of participants indicated that they would even consider seeking help from these providers in the future. However, it is important to note that for the current study, endorsing barriers to seeking help or having negative attitudes toward seeking help were unrelated to help-seeking status. Thus, this younger generation may not perceive a negative attitude or other barriers as reasons not to seek professional help. Additionally, it is possible that despite the fact that providers are still largely underutilized, undergraduate students may perceive fewer barriers to seeking professional help and may have overall more positive attitudes toward seeking help than older generations. In this way, perceived barriers and attitudes may be beginning to shift as the mental health field as a whole does more to create opportunities for individuals, couples, and families to access services.

The current study supports findings of previous studies that suggest that men underutilize formal services more frequently than women. Although males and females did not differ in their utilization of informal help sources, females were more likely than males to be currently seeking help from formal help sources and consider seeking help from formal help sources in the future. Thus, results indicate that there continues to be a gap in the utilization of services for males and females despite the fact that males scored higher on average than women on the Major Depression Inventory. Additionally, males and females did not differ in their perceived barriers to seeking professional help. However, females indicated more positive attitudes toward seeking professional help than males. This means that despite being similar in their perceived barriers,

women were more likely than men to be currently seeking formal help currently and more likely to consider seeking formal help in the future.

Strengths and Limitations

The current study had several strengths. First, the study provides an in depth understanding of the types of sexual problems faced in a sample of undergraduate students. Second, undergraduates represent a younger generation than has been previously studied in the past with regard to barriers, attitudes, seeking professional help, and provider preferences. Thus, this study provides an update to the literature on help-seeking utilizing a younger generation that can help researchers identify how trends in help-seeking are shifting. Third, the current study provides an in depth understanding of the types of barriers identified by a sample of undergraduate students, which can increase providers' understanding of the barriers in order to help clients circumvent them. Additionally, the study provides a greater understanding of the types of providers individuals prefer if they are experiencing sexual concerns. This information is helpful to professionals who focus specifically on the treatment of sexual concerns, as these types of professionals, ironically, tend to be among the most underutilized for sexual concerns. Having a baseline understanding of who is utilizing and not utilizing specialized services for sexual concerns helps providers better understand how to increase awareness of and access to services. Furthermore, undergraduates who completed the survey were able to consider their own concerns about sexual health. It is possible that for the current sample, awareness of the types of sexual concerns as well as awareness of the types of resources available encouraged participants to seek their own treatment or at least reflect and gain an understanding of their concerns. Last, the fact that the questionnaire was online was a strength of the study. Given the online nature of the current study, participants could complete the study anonymously. This allowed space for

participants to be more open and honest with their responses. This also allowed participants to access the study conveniently and increased their comfort because it could be completed at their leisure.

In addition to the strengths of the study, there were several limitations. First, self-selection bias was a threat to internal validity (Rosenthal & Rosnow, 2008). For example, it is possible that individuals who are more open about sexuality and more sexually active chose to participate in the study. Self-selection bias was even more possible due to the fact that it was an online survey, and the researcher could not assign participants, nor did she select a particular type of participant to respond to the invitation. All undergraduates at the target institution were welcome to participate. Second, participants' self-report bias was possible. For example, it is possible that undergraduates completing the study were not willing to disclose or admit to themselves that they have a problem. Further, undergraduates may have exaggerated the frequency of their sexual behavior, or the quality of their sexual functioning. Additionally, the current study did not screen for individuals who had not engaged in sexual activity in the past four weeks. This is because it was not required for participation in the study. However, because sexual inactivity in the past four weeks was not criteria for exclusion, it is possible that some participants who completed the sexual functioning questionnaires were unable to do so completely as they had not engaged in any sexual behavior in the past four weeks. It is unknown whether participants self-selected out of the survey if they had not engaged in sexual activity in the past four weeks. Unfortunately, the failure to use having had some sexual activity in the past four weeks as an inclusionary criterion was an oversight by the researchers. Future research should screen for the presence of recent sexual activity. Furthermore, the sample was a generally homogenous sample of white, heterosexual undergraduate students. The sample overall lacked

ethnic diversity and diversity of sexual orientations, which is a limitation of the current study. Last, a mixed qualitative and quantitative approach provides researchers with a more comprehensive understanding of the area of investigation. Thus, a potential limitation of the current study was that it was a strictly quantitative study, which was completed anonymously by participants online.

Future Research

Based on the findings of the current study, future research is necessary in order to better understand the sexual concerns faced by undergraduate students, their unique help-seeking behaviors, and their provider preferences. First, a better understanding of sexual development in the undergraduate sample would be important for understanding the etiology of their sexual concerns. Future researchers may consider conducting studies that compare students' sexual concerns for those who have become sexually active in the past few months with students' sexual concerns for those who have been sexually active for a year or more. Understanding the concerns that occur at different levels of sexual development can be helpful for professionals to better understand where and when to intervene. Future researchers may also consider conducting qualitative interviews regarding sexual concerns with undergraduate students. Quantitative and qualitative research when combined can provide the most comprehensive understanding of undergraduate sexual concerns.

Second, future researchers may consider screening for undergraduate students who have been sexually active in the past four weeks in order to obtain a more representative sample to discuss sexual concerns. Third, future researchers may consider conducting help-seeking studies entirely devoted to better understanding male help-seeking. The current study found that despite not endorsing more barriers or holding more negative attitudes toward help-seeking, males are

less likely than females to seek formal help. Future research can help provide a better understanding of this gap in services for males. Also, it is important for future researchers to obtain a more representative sample with regard to ethnicity, race, and sexual orientation in the study of sexual functioning concerns and help-seeking among undergraduate students. It is important to better understand a range of experiences for all types of diversity.

Additionally, qualitative and quantitative studies that focus on how mental health professionals address negative stigma, overcome barriers, and increase access to services would be an important future direction. There are many studies conducted that serve to better understand how clients underutilize services; however, less research has been conducted that focuses on understanding how mental health professionals are bridging the gap in services as well as how they can work to bridge that gap in the future. Lastly, future researchers may consider comparing younger generations to older generations with regard to attitudes toward seeking professional help, perceived barriers to seeking professional help, help-seeking behaviors, and provider preferences. This can help provide a better understanding of how help-seeking has shifted in the past several years and provide a better understanding of the areas that still need to be addressed.

Conclusion

Research that evaluates sexual functioning concerns among undergraduate students is lacking. In addition to this gap, there is less research on help-seeking that focuses on qualities of mental health professionals that contribute to barriers in help seeking. Research that seeks to understand these qualities as well as identify gaps in provider utilization is needed. The current study addresses this gap by gaining a broader understanding of specific help-seeking behaviors and provider preferences among undergraduate students. Furthermore, a study that addresses

service utilization and provider preference for the specific issue of sexual functioning is important as it addresses a highly prevalent issue and a public health concern.

A broader understanding of the barriers and specific providers that are underutilized may facilitate in developing sexual health promotion efforts on college campuses nationwide. The current study may also serve to increase clinicians' awareness of areas for improvement and encourage them to begin addressing these issues in therapy when working with undergraduate students. This study is intended to provide a deeper understanding of the occurrence of sexual functioning concerns among undergraduate students with an emphasis on the fact that the absence of sexual dysfunction does not equate to the presence of healthy sexual functioning. Understanding the specific concerns of undergraduate students may also provide information as to what health promotion focus is needed.

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Appendix A

Sexual Help Seeking

Exit and Complete Survey Later

Please read the statement below.

Principal Investigator: Rachel Tambling, PhD
Student Researcher: Ashley Reckert, BA
Study Title: Help-seeking for Sexual Functioning Concerns

Introduction

You are invited to participate in a research study that examines attitudes toward seeking help for sexual concerns and preferences for help among a variety of sources.

Why is this study being done?

The purpose of this research study is to explore the sexual concerns of undergraduate students and identify sources of help preferred by students. Gaining an understanding of these concerns and preferences can improve the quality of the resources available for students.

What are the study procedures? What will I be asked to do?

During this research session, you will be asked a series of questions about your sexual history and what your opinions and preferences are about seeking help for sexual concerns.

This study will take approximately 30 minutes to complete.

What are the risks or inconveniences of the study?

While the risks associated with this study are minimal, some of the questions may generate feelings of discomfort in you. You are free to not answer any questions that you do not want to, and you can discontinue participating at any time. The only inconvenience is the amount of time it will take you to complete the questionnaires, about 30 minutes.

Your confidentiality will be maintained to the degree permitted by the technology used. Specifically, no guarantees can be made regarding inception of the data sent via the Internet by any third parties.

What are the benefits of the study?

You may not directly benefit from this research; however, we hope that your participation in this study provides a greater understanding of the research process. Your participation in this study will help the researchers to learn more about what sexual concerns undergraduate students are facing and what help sources are preferred among students.

Will I receive payment for participation? Are there costs to participate?

For your participation, you can enter a one time drawing for one of 2 $50 Visa™ gift certificates. You must provide your email address to be entered in the drawing so that the researchers can notify you if you win. You do not have to enter the drawing to participate.

How will my personal information be protected?

The following procedures will be used to protect the confidentiality of your data. Data will be gathered through a secure website hosted through Psychsurveys.org, a program designed to collect internet-based data. We will ask you to supply your email address, if you wish, so that the researchers can contact you after this survey is over and so that you can be entered in the drawing for the gift cards. However, your email address will not be linked to your responses to the survey. Therefore, your responses to this study will remain anonymous, and the database of email addresses will be destroyed after the drawing has been administered.

You should also know that the UConn Institutional Review Board (IRB) and the Office of Research Compliance may inspect study records as part of its auditing program, but these reviews will only focus on the researchers and not on your responses or involvement. The IRB is a group of people who review research studies to protect the rights and welfare of research participants.

Can I stop being in the study and what are my rights?

You do not have to be in this study if you do not want to. If you agree to be in the study, but later change your mind, you may drop out at any time. There are no penalties or consequences of any kind if you decide that you do not want to participate.

Whom do I contact if I have questions about the study?

Take as long as you like before you make a decision. We will be happy to answer any question you have about this study. If you have further questions about this project or if you have a research-related problem, you may contact the principal investigator, Rachel Tambling (rachel.tambling@uconn.edu) or the student researcher, Ashley Reckert (ashley.reckert@uconn.edu). If you have any questions concerning your rights as a research subject, you may contact the University of Connecticut Institutional Review Board (IRB) at 860-486-8802.

1: By checking this box, you certify that you are 18 years of age or older. ☐

	Yes, I have read the participation details and would like to participate in the survey.	No, I would not like to participate.
2: Would you like to participate in this study?	○	○

	Male	Female
3: Please indicate your biological sex	○	○

4: By checking this box, you certify that you are an undergraduate student. ☐

Continue to Next Page

Sexual Help Seeking

Exit and Complete Survey Later

Female Sexuality Questionnaires

	Almost always or always	Most times (more than half the time)	Sometimes	A few times (less than half the time)	Almost never or never
1: Over the past 4 weeks, how often did you feel sexual desire or interest?	○	○	○	○	○

	Very high	High	Moderate	Low	Very low or none at all
2: Over the past 4 weeks, how would you rate your level (degree) of sexual desire or interest?	○	○	○	○	○

	No sexual activity	Almost always or always	Most times (more than half the time)	Sometimes (aboult half the time)	A few times (less than half the time)	Almost never or never
3: Over the past 4 weeks, how often did you feel sexually aroused ("turned on") during sexual activity or intercourse?	○	○	○	○	○	○

	No sexual activity	Very high	High	Moderate	Low	Very low or none at all
4: Over the past 4 weeks, how would you rate your level of arousal ("feeling turned on") during sexual activity or intercourse?	○	○	○	○	○	○

	No sexual activity	Very high confidence	High confidence	Moderate confidence	Low confidence	Very low or no confidence
5: Over the past 4 weeks, how confident were you about becoming sexually aroused during sexual activity or intercourse?	○	○	○	○	○	○

	No sexual activity	Almost always or always	Most times (more than half the time)	Sometimes (aboult half the time)	A few times (less than half the time)	Almost never or never
6: Over the past 4 weeks, how often have you been satisfied with your arousal (excitement) during sexual activity or intercourse?	○	○	○	○	○	○

	No sexual activity	Almost always or always	Most times (more than half the time)	Sometimes (aboult half the time)	A few times (less than half the time)	Almost never or never
7: Over the past 4 weeks, how often did you become lubricated ("wet") during sexual activity or intercourse?	○	○	○	○	○	○

	No sexual activity	Extremely difficult or impossible	Very difficult	Difficult	Slightly difficult	Not difficult
8: Over the past 4 weeks, how difficult was it to become lubricated ("wet") during sexual activity or intercourse?	○	○	○	○	○	○

	No sexual activity	Almost always or always	Most times (more than half the time)	Sometimes (about half the time)	A few times (less than half the time)	Almost never or never
9: Over the past 4 weeks, how often did you maintian your lubrication ("wetness") until completion of sexual activity or intercourse?	○	○	○	○	○	○

	No sexual activity	Extremely difficult or impossible	Very difficult	Difficult	Slightly difficult	Not difficult
10: Over the past 4 weeks, how difficult was it to maintain your lubrication ("wetness") until completion of sexual activity or intercourse?	○	○	○	○	○	○

	No sexual activity	Almost always or always	Most times (more than half the time)	Sometimes (about half the time)	A few times (less than half the time)	Almost never or never
11: Over the past 4 weeks, when you had sexual stimulation or intercourse, how often did you reach orgasm (climax)?	○	○	○	○	○	○

	No sexual activity	Extremely difficult or impossible	Very difficult	Difficult	Slightly difficult	Not difficult
12: Over the past 4 weeks, when you had sexual stimulation or intercourse, how difficult was it for you to reach orgasm (climax)?	○	○	○	○	○	○

	No sexual activity	Very satisfied	Moderately satisfied	About equally satisfied and dissatisfied	Moderately dissatisfied	Very dissatisfied
13: Over the past 4 weeks, how satisfied were you with your ability to reach orgasm (climax) during sexual activity or intercourse?	○	○	○	○	○	○

	No sexual activity	Very satisfied	Moderately satisfied	About equally satisfied and dissatisfied	Moderately dissatisfied	Very dissatisfied
14: Over the past 4 weeks, how satisfied have you been with the amount of emotional closeness during sexual activity between you and your partner?	○	○	○	○	○	○

	Very satisfied	Moderately satisfied	About equally satisfied and dissatisfied	Moderately dissatisfied	Very dissatisfied
15: Over the past 4 weeks, how satisfied have you been with your sexual relationship with your partner?	○	○	○	○	○

	Very satisfied	Moderately satisfied	About equally satisfied and dissatisfied	Moderately dissatisfied	Very dissatisfied
16: Over the past 4 weeks, how satisfied have you been with your overall sexual life?	○	○	○	○	○

	Did not attempt intercourse	Almost always or always	Most times (more than half the time)	Sometimes (about half the time)	A few times (less than half the time)	Almost never or never
17: Over the past 4 weeks, how often did you experience discomfort or pain during vaginal penetration?	○	○	○	○	○	○

	Did not attempt intercourse	Almost always or always	Most times (more than half the time)	Sometimes (about half the time)	A few times (less than half the time)	Almost never or never

18: Over the past 4 weeks, how often did you experience discomfort or pain following vaginal penetration?	○	○	○	○	○	○

	Did not attempt intercourse	Very high	High	Moderate	Low	Very low or none at all
19: Over the past 4 weeks, how would you rate your level (degree) of discomfort or pain during or following vaginal penetration?	○	○	○	○	○	○

	Never	Rarely	Sometimes	Usually	Always
20: How often does consuming alcohol contribute to problems with your own sexual functioning?	○	○	○	○	○

Rate each statement below according to how much you agree or disagree with the statement by circling one of six response choices.

	Completely agree	Moderately agree	Slightly agree	Slightly disagree	Moderately disagree	Completely disagree
21: When I think about my sex life, it is an enjoyable part of my overall life.	○	○	○	○	○	○
22: When I think about my sex life, I feel frustrated.	○	○	○	○	○	○
23: When I think about my sex life, I feel depressed.	○	○	○	○	○	○
24: When I think about my sex life, I feel like less of a woman.	○	○	○	○	○	○
25: When I think about my sex life, I feel good about myself.	○	○	○	○	○	○
26: I have lost confidence in myself as a sexual partner.	○	○	○	○	○	○
27: When I think about my sex life, I feel anxious.	○	○	○	○	○	○
28: When I think about my sex life, I feel angry.	○	○	○	○	○	○
29: When I think about my sex life, I feel close to my partner.	○	○	○	○	○	○
30: I worry about the future of my sex life.	○	○	○	○	○	○
31: I have lost pleasure in sexual activity.	○	○	○	○	○	○
32: When I think about my sex life, I feel embarrassed.	○	○	○	○	○	○
33: When I think about my sex life, I feel that I can talk to my partner about sexual matters.	○	○	○	○	○	○
34: I try to avoid sexual activity.	○	○	○	○	○	○
35: When I think about my sex life, I feel guilty.	○	○	○	○	○	○
36: When I think about my sex life, I worry that my partner feels hurt or rejected.	○	○	○	○	○	○
37: When I think about my sex life, I feel like I have lost something.	○	○	○	○	○	○
38: When I think about my sex life, I am satisfied with the frequency of sexual activity.	○	○	○	○	○	○

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Sexual Help Seeking

Exit and Complete Survey Later

Male Sexuality Questionnaires

	Yes	No	Not sure
1: Are you circumcised?	○	○	○

New Matrix Item Text

	No sexual activity	Almost always or always	Most times (much more than half the time)	Sometimes (about half the time)	A few times (much less than half the time)	Almost never or never
2: Over the last month, how often were you able to get an erection during sexual activity?	○	○	○	○	○	○
3: Over the last month, when you had erections with sexual stimulation, how often were your erections hard enough for penetration?	○	○	○	○	○	○
4: Over the last month, when you attempted intercourse, how often were you able to penetrate your partner?	○	○	○	○	○	○
5: Over the last month, during sexual intercourse, how often were you able to maintain your erection after you had penetrated your partner?	○	○	○	○	○	○

	No sexual activity	Extremely difficult	Very difficult	Difficult	Slightly difficult	Not difficult
6: Over the last month, during sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	○	○	○	○	○	○

	No attempts	1-2 times	3-4 times	5-6 times	7-10 times	11-20 times
7: Over the last month, how many times have you attempted sexual intercourse?	○	○	○	○	○	○

	Did not attempt intercourse	Almost always or always	Most times (much more than half the time)	Sometimes (about half the time)	A few times (much less than half the time)	Almost never or never
8: Over the last month, when you attempted sexual intercourse how often was it satisfactory for you?	○	○	○	○	○	○

	No intercourse	Very highly enjoyable	Highly enjoyable	Fairly enjoyable	Not very enjoyable	No enjoyment
9: Over the last month, how much have you enjoyed sexual intercourse?	○	○	○	○	○	○

	No sexual stimulation/intercourse	Almost always or always	Most times (much more than half the time)	Sometimes (about half the time)	A few times (much less than half the time)	Almost never or never
10: Over the last month, when you had sexual stimulation or intercourse, how often did you ejaculate?	○	○	○	○	○	○

	No sexual stimulation/intercourse	Almost always or always	Most times (much more than half the time)	Sometimes (about half the time)	A few times (much less than half the time)	Almost never or never
11: Over the last month, when you had sexual stimulation or intercourse, how often did you have the feeling of orgasm (with or without ejaculation)?	○	○	○	○	○	○

	Almost always or always	Most times (much more than half the time)	Sometimes (about half the time)	A few times (much less than half the time)	Almost never or never
12: Over the last month, how often have you felt sexual desire?	○	○	○	○	○

	Very high	High	Moderate	Low	Very low or not at all
13: Over the last month, how would you rate your level of sexual desire?	○	○	○	○	○

	Very satisfied	Moderately satisfied	Abouth equally satisfied and dissatisfied	Moderately dissatisfied	Very dissatisfied
14: Over the last month, how satisfied have you been with your overall sex life?	○	○	○	○	○

	Very satisfied	Moderately satisfied	Abouth equally satisfied and dissatisfied	Moderately dissatisfied	Very dissatisfied
15: Over the last month, how satisfied have you been with your sexual relationship with your partner?	○	○	○	○	○

	Very high	High	Moderate	Low	Very low
16: Over the last month, how do you rate your confidence that you can get and keep your erection?	○	○	○	○	○

	No sexual intercourse (not applicable)	Almost always or always	More than half the time	About half the time	Less than half the time	Almost never or never
17: Over the past 4 weeks, when you had sexual intercourse, how often did you have control over when you ejaculated?	○	○	○	○	○	○

	No sexual intercourse (not applicable)	High confidence	Moderately high confidence	Neither high nor low confidence	Moderately low confidence	Low confidence
18: Over the past 4 weeks, when you had sexual intercourse, how much confidence did you have over when you ejaculated?	○	○	○	○	○	○

	No sexual intercourse (not applicable)	Almost always or always	More than half the time	About half the time	Less than half the time	Almost never or never
19: Over the past 4 weeks, when you had sexual intercourse, how often was it satisfactory for you?	○	○	○	○	○	○

	No sexual intercourse (not applicable)	Very satisfied	Somewhat satisfied	Neither satisfied nor dissatisfied	Somewhat dissatisfied	Very dissatisfied
20: Over the past 4 weeks, when you had sexual intercourse, how satisfied were you with your sense of control over when you ejaculated?	○	○	○	○	○	○

Sexual Help Seeking

Exit and Complete Survey Later

Sexual History, Experience, and Behaviors

In the following question, please indicate how often you and your partner do each of the sexual activities listed by clicking on the circle for the number that most accurately describes your experiences.

	Often 1	2	Sometimes 3	4	Never 5
1: Seeing my partner nude	○	○	○	○	○
2: Being seen nude by my partner	○	○	○	○	○
3: Lip kissing	○	○	○	○	○
4: Tongue kissing	○	○	○	○	○
5: Touching partner's body except for genitals	○	○	○	○	○
6: Having partner touch my body, except for genitals	○	○	○	○	○
7: Kissing partner's body	○	○	○	○	○
8: Having my body kissed	○	○	○	○	○
9: Caressing my own genitals with partner present	○	○	○	○	○
10: Caressing partner's genitals	○	○	○	○	○
11: Having my genitals caressed	○	○	○	○	○
12: Kissing partner's genitals	○	○	○	○	○
13: Having my genitals kissed	○	○	○	○	○
14: Bringing partner to climax with my hand	○	○	○	○	○
15: Being brought to climax with my partner's hand	○	○	○	○	○
16: Bringing partner to climax with my mouth	○	○	○	○	○
17: Being brought to climax with my partner's mouth	○	○	○	○	○
18: Just having intercourse with neither climaxing	○	○	○	○	○
19: Having intercourse where only I climax	○	○	○	○	○
20: Having intercourse where only my partner climaxes	○	○	○	○	○
21: Having intercourse with both climaxing	○	○	○	○	○
22: Having anal intercourse	○	○	○	○	○
23: Other sexual interests	○	○	○	○	○

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Sexual Help Seeking

Exit and Complete Survey Later

Help-seeking Attitudes and Behaviors

To what extent do you agree or disagree with the statements below:

	Agree	Partly agree	Partly disagree	Disagree
1: If I believed I was having a mental breakdown, my first inclination would be to get professional attention.	O	O	O	O
2: The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.	O	O	O	O
3: If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.	O	O	O	O
4: There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help.	O	O	O	O
5: I would want to get psychological help if I were worried or upset for a long period of time.	O	O	O	O
6: I might want to have psychological counseling in the future.	O	O	O	O
7: A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help.	O	O	O	O
8: Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.	O	O	O	O
9: A person should work out his or her own problems; getting psychological counseling would be a last resort.	O	O	O	O
10: Personal and emotional troubles, like many things, tend to work out by themselves.	O	O	O	O

Of the following help sources available for sexual concerns, please identify which sources you have used in the past, are currently using, and/or would consider using in the future. Please check all that apply.

	I have sought help from (check all that apply)	I am currently seeking help now from (check all that apply)	I would seek help from (check all that apply)
11: None	☐	☐	☐
12: Internet, newspaper, magazine, television, and/or informational pamphlet	☐	☐	☐
13: Help-line	☐	☐	☐
14: Friend	☐	☐	☐
15: Family members	☐	☐	☐
16: Member of the clergy or church official	☐	☐	☐
17: Mentor and/or teacher	☐	☐	☐
18: Peer educator	☐	☐	☐
19: Planned Parenthood, sex educator	☐	☐	☐
20: Mental health professional	☐	☐	☐
21: Gynecologist	☐	☐	☐
22: Primary Care Physician	☐	☐	☐
	☐	☐	☐

23: Other

Of the following mental health service providers available for sexual concerns, please identify which sources you have used in the past, are currently using, and/or would consider using in the future. Please check all that apply.

	I have sought help from (check all that apply)	I am currently seeking help now from (check all that apply)	I would seek help from (check all that apply)
24: None	☐	☐	☐
25: Psychiatrist	☐	☐	☐
26: Psychologist	☐	☐	☐
27: Professional Counselor	☐	☐	☐
28: Social Worker	☐	☐	☐
29: Marriage and Family Therapist	☐	☐	☐
30: Psychiatric Nurse	☐	☐	☐
31: Sex Counselor	☐	☐	☐
32: Sex Therapist	☐	☐	☐
33: Other	☐	☐	☐

Please indicate how much you agree with the following statements.

	Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree
34: I would not seek help from mental health professionals for sexual concerns because I do not trust mental health workers.	○	○	○	○	○	○
35: I would not seek help from mental health professionals for sexual concerns because I would see it as a sign of personal weakness and/or that I have failed.	○	○	○	○	○	○
36: I would not seek help from mental health professionals for sexual concerns because I prefer to deal with problems on my own.	○	○	○	○	○	○
37: I would not seek help from mental health professionals for sexual concerns because I do not believe that therapy is helpful.	○	○	○	○	○	○
38: I would not seek help from mental health professionals for sexual concerns because I have had a negative experience in the past.	○	○	○	○	○	○
39: I would not seek help from mental health professionals for sexual concerns because I would not be able to remain anonymous.	○	○	○	○	○	○
40: I would not seek help from mental health professionals for sexual concerns because I prefer to talk to friends and family about sexual concerns.	○	○	○	○	○	○
41: I would not seek help from mental health professionals for sexual concerns because I am embarrassed.	○	○	○	○	○	○
42: I would not seek help from mental health professionals for sexual concerns because I do not think I have a problem and/or I do not want to change.	○	○	○	○	○	○
43: I would not seek help from mental health professionals for sexual concerns because I fear that I would be judged and/or stereotyped.	○	○	○	○	○	○
44: I would not seek help from mental health professionals for sexual concerns because I do not believe a mental health professional would share my beliefs.	○	○	○	○	○	○
45: I would not seek help from mental health professionals for sexual concerns because I do not believe a mental health professional would be the same race as me.	○	○	○	○	○	○
46: I would not seek help from mental health professionals for sexual concerns because I do not believe a mental health professional would be the same sexual orientation as me.	○	○	○	○	○	○

47: I would not seek help from mental health professionals for sexual concerns because I do not believe a mental health professional would be the same biological sex as me.	○	○	○	○	○	○
48: I would not seek help from mental health professionals for sexual concerns because I do not believe a mental health professional would come from the same socio-economic class as me.	○	○	○	○	○	○
49: I would not seek help from mental health professionals for sexual concerns because I believe mental health professionals lack strong credentials.	○	○	○	○	○	○
50: I would not seek help from mental health professionals for sexual concerns because I do not have transportation available to attend therapy.	○	○	○	○	○	○
51: I would not seek help from mental health professionals for sexual concerns because it is too expensive to attend therapy.	○	○	○	○	○	○
52: I would not seek help from mental health professionals for sexual concerns because my insurance does not cover attending therapy.	○	○	○	○	○	○
53: I would not seek help from mental health professionals for sexual concerns because I do not have enough time to attend therapy.	○	○	○	○	○	○
54: I would not seek help from mental health professionals for sexual concerns because I do not know which providers in the area specialize in sexual concerns.	○	○	○	○	○	○
55: I would not seek help from mental health professionals for sexual concerns because the waitlist to be seen is too long.	○	○	○	○	○	○

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Sexual Help Seeking

Exit and Complete Survey Later

Mental Health Questionnaires

Over the last TWO weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1: Feeling nervous, anxious, or on edge	○	○	○	○
2: Not being able to stop or control worrying	○	○	○	○
3: Worrying too much about different things	○	○	○	○
4: Trouble relaxing	○	○	○	○
5: Being so restless that it's hard to sit still	○	○	○	○
6: Becoming annoyed or irritable	○	○	○	○
7: Feeling afraid as if something awful might happen	○	○	○	○

8: If you identified any problems above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all ○
- Somewhat difficult ○
- Very difficult ○
- Extremely difficult ○

In the last TWO weeks, how much of the time have you...

	All of the time	Most of the time	More than half the time	Less than half the time	Some of the time	At no time
9: Felt sad or down in the dumps	○	○	○	○	○	○
10: Lost interest in your daily activities	○	○	○	○	○	○
11: Lacked strength and energy	○	○	○	○	○	○
12: Felt less self-confident	○	○	○	○	○	○
13: Felt guilty or had a nagging conscience	○	○	○	○	○	○
14: Felt that life wasn't worth living	○	○	○	○	○	○
15: Had difficulty concentrating (e.g. when reading the newspaper or watching television)	○	○	○	○	○	○
16: Felt very restless	○	○	○	○	○	○
17: Felt subdued	○	○	○	○	○	○
18: Had trouble sleeping at night	○	○	○	○	○	○
19: Suffered from reduced appetite	○	○	○	○	○	○
20: Suffered from increased appetite	○	○	○	○	○	○

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Sexual Help Seeking

Exit and Complete Survey Later

Demographic Information

1: Biological Sex:

- Male ○
- Female ○
- Intersex ○

2: Which of the following terms best describes your sexual orientation?

- Heterosexual ○
- Gay or lesbian ○
- Bisexual ○
- Transgender ○
- Questioning ○
- Other ○

3: What year are you in school?

- Freshman (1st year) ○
- Sophomore (2nd year) ○
- Junior (3rd year) ○
- Senior (4th year) ○
- 5th year+ undergraduate student ○

4: Age:

5: Race/Ethnicity:

- African ○
- American Indian/Alaska Native/First Nation ○
- Asian Native Hawiian or other Pacific Islander ○
- Black or African American ○
- White non-Hispanic/Latino ○
- White Hispanic/Latino ○
- Other Native group ○
- More than one race ○
- Other ○

6: What is your current health status?

- Very healthy ○
- Healthy ○
- Somewhat healthy ○
- Average ○
- Somewhat unhealthy ○
- Unhealthy ○
- Very unhealthy ○

7: Rate your level of alcohol use.

- I drink more than most undergraduates ○
- I drink more than some undergraduates ○
- I drink about the same as most undergraduates ○
- I drink less than some undergraduates ○
- I drink less than most undergraduates ○

8: What is your current relationship status?

- Single (not in a relationship) ○
- Committed monogamous relationship ○
- Committed nonmonogamous relationship ○
- Non-committed monogamous relationship ○
- Non-committed nonmonogamous relationship ○
- Cohabitating monogamous relationship ○
- Cohabitating nonmonogamous relationship ○
- Married and monogamous ○
- Married and nonmonogamous ○
- Other ○

9: Have you ever been diagnosed with a sexually transmitted disease?

- Yes ○
- No ○
- Not Sure ○

What is your current employment status?

Check all that apply

- 10: Employed full time ☐
- 11: Unable to work ☐
- 12: Retired ☐
- 13: Employed part time ☐
- 14: Volunteer work ☐
- 15: Student ☐
- 16: Unemployed ☐
- 17: Caring for family members ☐
- 18: Other ☐

19: Please enter your email address here if you wish to be included in the gift card drawing. This email address will be kept separate from survey responses. You do not have to enter your email address unless you wish to be entered in the drawing.

20: You may include here any additional information you wish the researchers to know about you, or about your response to this survey.

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Sexual Help Seeking

Sexual Concerns and Preferences for Seeking Help

Thank you for participating in this study.

Please close your browser to exit.

If you have any questions or concerns, you may contact the researcher, Ashley Reckert (ashley.reckert@uconn.edu) at any time.