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Effects of Mental Health Clinician Characteristics and Education on Willingness to Treat Child Problematic Sexual Behavior

Debra Elise Hutchison
Walden University

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Walden University

College of Psychology and Community Services

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Debra Elise Hutchison

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Walden University
2025

Abstract

Effects of Mental Health Clinician Characteristics and Education on Willingness to Treat

Child Problematic Sexual Behavior

by

Debra Elise Hutchison

MS, Eastern Washington University, 2015

BS, Pennsylvania State University, 2012

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Psychology

Walden University

November 2025

Abstract

Children aged 12 and under who exhibit problematic sexual behavior (PSB) often face barriers to care due to clinicians' limited willingness and effectiveness in treating this population. However, little is known about the factors that influence clinicians' willingness to provide treatment. Grounded in Bowen's family systems theory and Bandura's self-efficacy theory, this study examined how differentiation of self (DoS), sexual intervention self-efficacy (SISE), sexual comfort, and sexual education/training affect clinicians' willingness to treat child PSB. A quantitative, non-experimental survey design with a convenience sample of 63 clinicians with experience working with children used a multiple linear regression analysis that revealed a statistically significant model; however, no single variable emerged as an independent predictor. A second model was analyzed, as assumptions and initial model results indicated that SISE and sexual comfort were likely contributing predictors. Sexual comfort was the sole individual predictor, accounting for 22% of the variance. Demographic data confirmed clinicians' limited willingness to treat child PSB (most clinicians reported treating children with PSB, but half did not address PSB during treatment), high rates of personal histories of sexual trauma, and PSB were reported. Clinicians with greater exposure to child PSB cases reported higher willingness to treat. These findings highlight the need for targeted fostering of sexual comfort and early-career exposure to support increased willingness to treat child PSB, ultimately increasing treatment engagement with this client population. Such efforts may support social change through expanded access to care and reduced child-on-child sexual abuse, mitigating long-term harm and societal costs.

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Dedication

I dedicate my dissertation to the many clients I have had the sincere honor and privilege of serving over my career who have either experienced PSB, supported someone with PSB, or been negatively impacted by PSB. These individuals have been inspiring to work with and have fostered an unrelenting passion within myself to seek out positive social change for the treatment of this population as well as for their support systems. Their unrelenting resiliency in the face of their pain, hardship, and traumatic life experiences continues to give me hope, faith, and passion to advocate for this client population, public mental health, and community safety at large, which is a gift which I can never fully repay. I would also like to dedicate this dissertation to my husband Christopher Hutchison, children Alastor and Aria as well as my mother Debra Stewart. They are my rocks, my support, and my personal source of resilience when I need to recharge my batteries. Each of you have given up things across this journey in the name of my dreams and passions. Your support, cheerleading, confidence-building and love have allowed me to get this far in moving toward my dreams and aspirations and I know each of you will continue to hold me up to carry me forward to many future finish lines in the name of positive social change. You are amazing change agents for the community, and I could not have done it without you.

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Chapter 1: Introduction to the Study

Therapists, counselors, and social workers are typically seen as working in what is referred to as “the helping profession.” Each of these unique subfields of professionals have their own set of ethical codes and standards that clearly state that a priority of their profession is to provide support to all populations of clients in a non-judgmental and effective manner (American Psychological Association [APA], 2022). Several codes of ethics state explicitly that if they are not competent or confident in a specific subspecialty of mental health counseling, it is their professional and ethical obligation to overcome any gaps in biases, competencies, and training. However, in practice, this is not what happens when it comes to the treatment of child problematic sexual behavior (PSB), as clinicians are less willing to treat these clients (Miller & Byers, 2012). It is common for mental health clinicians to refer clients to other mental health clinicians or refuse to treat them without providing an alternate referral (Heiden-Rootes et al., 2017; Malvaso et al., 2019; McKibbin 2017; Shields et al., 2018; Shields et al., 2020; Short et al., 2016; Taylor et al., 2020; Tener et al., 2019). Although studies have shown this occurs with challenging and complex client populations or diagnoses such as borderline personality disorder, it is most common in clients with any concern related to sexuality (Heiden-Rootes et al., 2017). These presenting issues can include couples’ sex counseling, gender identity concerns, sex offender treatment, sexual trauma, and PSB (Heiden-Rootes et al., 2017).

Currently research has begun to address mental health clinicians’ lack of willingness to engage in treatment with these presenting problems. However, a large gap

exists in the treatment for children 12 and younger who present concerns with PSB (Malvaso et al., 2019; McKibbin, 2017). PSB in children ages 12 and younger is defined as behaviors involving sexual body parts (i.e., genitals, anus, buttocks, or breasts) that are developmentally inappropriate or potentially harmful to themselves or others (Chaffin et al., 2008). The previous research in this area has primarily focused on barriers related to clinician willingness to treat sexual issues in adolescents and adults, but few studies have addressed the significant issues faced by children attempting to gain effective treatment for PSB (Malvaso et al., 2019; McKibbin, 2017). This is of particular concern, as treatment of the issue of PSB in childhood shows that if children have access to effective non-judgmental treatment, it is likely that the concern will go into full remission long-term, reducing the number of adolescents and adults who would have a need to address these concerns later in life once they have become more ingrained behaviors (Belluardo-Crosby, 2011; Jenkins et al., 2020; Malvaso et al., 2019; McKibbin, 2017; Shields et al., 2020; Shields et al., 2018; Taylor et al., 2020; Tener et al., 2019).

The present study investigated what factors contribute to mental health clinicians' lack of willingness to treat children who exhibit PSB. This topic requires further investigation to address the broad lack of willingness among mental health clinicians to provide PSB treatment to children (Belluardo-Crosby, 2011; Jenkins et al., 2020; Shields et al., 2020; Short et al., 2016). The present study has several implications for future positive social change. In the short term, study results create a foundation for researchers and practitioners to better understand what factors affect mental health clinician willingness to treat children who exhibit PSB. This improved understanding of factors

that facilitate this willingness may lead to further studies that could develop more effective education, training, and supervision programs for mental health clinicians that would allow mental health clinicians to develop willingness to work with children who exhibit PSB, which can further lead increased clinician effectiveness and perception of self-efficacy in the treatment. Increased access to effective treatment as well as early intervention can significantly reduce the rate of overall child sexual abuse (CSA) rates, as a significant portion of CSA is initiated by other children rather than adult pedophiles, which is a common CSA myth (Heiden-Rootes et al., 2017; Malvaso et al., 2019; McKibbin 2017; Shields et al., 2018; Shields et al., 2020; Short et al., 2016; Taylor et al., 2020; Tener et al., 2019). These broad potential social change implications are important as the amount of CSA in the United States has been on the rise and continues to strain the public health system (Belluardo-Crosby, 2011; Jenkins et al., 2020; Malvaso et al., 2019; McKibbin, 2017; Shields et al., 2020; Shields et al., 2018; Taylor et al., 2020; Tener et al., 2019).

Chapter 1 provides an overview of the treatment of PSB in children ages 12 and younger with the focus on mental health clinician willingness to effectively provide mental health treatment to this population of clients. Additionally, background information for key relevant issues of the study phenomenon, factors that contribute to mental health clinician willingness to treat PSB in children aged 12 and younger, and other identified variables that may be predictors of clinician willingness are discussed. Research questions and hypotheses, theoretical foundation, nature of the study, limitations, significance, and assumptions are addressed. Chapter 1 will conclude with a

summary of the main points of the chapter.

Background

CSA is a widely researched topic across a variety of interdisciplinary fields such as criminal justice, medical, social, and behavioral sciences. CSA has a negative impact on the public health system, human services industry, and community at large (Belluardo-Crosby, 2011; Jenkins et al., 2020; Malvaso et al., 2019; McKibbin, 2017; Shields et al., 2020; Shields et al., 2018; Taylor et al., 2020; Tener et al., 2019). But the current system of financial resources, providers, and public information is insufficient to address the volume of new cases of CSA reported in the United States each year, let alone most cases of CSA that go unreported and unsupported. Less widely known, but supported by significant evidence, is that most CSA cases are those in which the child has been sexually abused by another child (Finkelhor et al., 2009). This information suggests that pivoting a focus from adult pedophiles and sex offenders to children 12 and younger who exhibit PSB could help in preventing CSA rates (Jenkins et al., 2020). Although this population represents the group that causes the majority of CSA, it has had the least number of resources, funding, research, or even acknowledgement by public, professional, and academic communities (Heiden-Rootes et al., 2017).

Due to this problem being under researched, few previous studies exist on the topic of PSB in children (Jenkins et al., 2020). The few studies that have established a foundation for this topic emphasize the need for further studies to help develop an understanding of PSB typologies, effective treatment strategies, and the barriers to client access to treatment (Belluardo-Crosby, 2011; Jenkins et al., 2020; Malvaso et al., 2019,

McKibbin, 2017; Shields et al., 2020; Shields et al., 2018; Taylor et al., 2020; Tener et al., 2019). Several qualitative studies have been conducted to obtain the perspective of clients, family members of clients, and professionals who work with children who exhibit PSB to develop and explore potential barriers to the identification, assessment, and effective treatment of PSB (Belluardo-Crosby, 2011; Jenkins et al., 2020; Malvaso et al., 2019; McKibbin, 2017; Shields et al., 2020; Shields et al., 2018; Taylor et al., 2020; Tener et al., 2019). The common factor identified across studies by all interviewed populations was that there are currently not enough mental health providers who are willing and able to effectively work with PSB clients and families (Malvaso et al., 2019; McKibbin, 2017), which affects access to care (Heiden-Rootes et al., 2017; Malvaso et al., 2019; McKibbin, 2017; Shields et al., 2020; Shields et al., 2018; Short et al., 2016; Taylor et al., 2020; Tener et al., 2019). Additional providers are needed to be effective at working with child PSB clients so that early PSB intervention and prevention can be addressed, ultimately providing a treatment pathway to reduce recidivism and PSB rates in adolescents and adults (Malvaso et al., 2019; McKibbin, 2017). Addressing this issue has the long-term potential to result in the reduction of CSA committed by adolescents and adults, not just CSA acted out by other children (Malvaso et al., 2019; McKibbin, 2017).

To be able to move toward this identified potential social change, it is necessary to better understand the factors that contribute to clients' lack of access to treatment for PSB. The current academic literature identifies four potential contributing factors to mental health clinician willingness to treat PSB: (a) sexuality-specific education and

training, (b) sexual comfort, (c) sexual intervention self-efficacy (SISE), and (d) differentiation of self (DoS; Belluardo-Crosby, 2011; Heiden-Rootes et al., 2017; Jenkins et al., 2020; Miller & Byers, 2008, 2012; Shields et al., 2020; Short et al., 2016).

Clinicians are without adequate training, tools, supervision, and education to work effectively with PSB client populations (Belluardo-Brosby, 2011; Jenkins et al., 2020; Shields et al., 2020; Short et al., 2016).

Additionally, lower levels of sexual comfort likely result in lower willingness to treat PSB in clients, resulting in higher rates of referrals to other providers or a complete avoidance of the PSB by the mental health provider during treatment (Heiden-Rootes et al., 2017). In contrast, higher levels of sexual comfort are correlated with increased likelihood to address the clients presenting PSB-related concerns (Heiden-Rootes et al., 2017). SISE includes subfactors of bias, skill, and knowledge, connecting to sexuality-specific education and sexual comfort on willingness to work with clients on issues related to sexuality while in treatment (Miller & Byers, 2008, 2012; Short et al., 2016).

The final factor related to mental health clinician willingness to treat PSB is DoS. Mental health clinicians with higher levels of DoS are reported to have more ability and willingness to effectively treat the clients' sexual concerns. This indicates that mental health clinicians who have a stronger natural ability to be emotionally distanced from the clients they treat and the subject matter addressed in treatment (i.e., high DoS) are more willing to engage in the treatment, to ask probing questions to identify the need for this treatment when not explicitly identified by the client, and are more likely to successfully engage in sexual-specific treatment interventions for treating sexual issues (Heiden-

Rootes et al., 2017).

The present study addressed the identified gaps in the academic literature. It focused on a population of mental health clinicians at the master's level, as they provide the majority of direct outpatient treatment services, in contrast with previous studies on paraprofessionals, whose role is not to address the PSB but to support their clients in enrollment in and adherence to treatment, and psychologists, who rarely provide direct ongoing weekly client care due to their high level of education and provider sparsity. Previous studies have only focused on adolescent and adult populations without much investigation into children 12 and under who exhibit PSB. This gap was addressed as the primary client population of target as this population attaining treatment access has the greatest potential for overall reduction of CSA to reduce the strain on the public health and human service industries (Belluardo-Crosby, 2011; Jenkins et al., 2020; Malvaso et al., 2019; McKibbin, 2017; Shields et al., 2020; Shields et al., 2018; Taylor et al., 2020; Tener et al., 2019). Finally, this study built on previous research to analyze the effects, interactions, and relationships of DoS, SISE, sexual comfort and sexuality-specific education, and training on mental health clinicians' willingness to provide treatment for PSB to children aged 12 and younger. A better understanding of these variables' interactions provides a better understanding of how best to move forward with the development of education, training, and supervision for mental health clinicians that will elicit willingness and effectiveness in the treatment of children who exhibit PSB.

Problem Statement

CSA is a prevalent international issue that affects community mental health

agencies, juvenile justice systems, medical facilities, child advocacy centers, and public schools (Belluardo-Crosby, 2011; Joannides, 2012; Malvaso et al., 2019; McKibbin, 2017; Tener et al., 2019). Though it a significant amount of CSA is perpetrated by other children, little research has been conducted around the prevention and treatment of PSB) exhibited by children ages 12 and younger or around the mental health clinicians who carry the responsibility of effectively providing treatment to this population (Malvaso et al., 2019). These clients and their families report issues locating and engaging in PSB treatment (Shields et al., 2018). Mental health clinicians and various professional supports report a lack of knowledge, skills, and comfort in addressing PSB in treatment (Short et al., 2016).

Topics of clients' sexual issues are among the most difficult and uncomfortable for mental health clinicians to treat (Anderson, 1986; Hanzlik & Gaubatz, 2012; Harris & Hays, 2008). More recently researchers have found that mental health clinicians' sexual comfort/bias, sexuality-specific knowledge, sexual treatment skills (sexual intervention self-efficacy), and their ability to maintain an emotionally regulated state in the presence of client dysregulation and discomfort (differentiation of self) may be directly related to an increased willingness to work with adult and adolescent clients who seek treatment for sexual concerns (Heiden-Rootes et al., 2017; Miller & Byers, 2008, 2010, 2012; Short et al., 2016). Increased sexuality-specific education and training has been shown to have a direct positive correlation with sexual comfort and willingness to treat adult clients presenting with sexual issues (Heiden-Rootes et al., 2017). Clinicians individual characteristics (gender, age, etc.) and amount of experience working with clients with

sexual concerns were not found to have a relationship with clinician sexual comfort or willingness to work with this client population (Hanzlik & Gaubatz, 2012; Miller & Byers, 2010). Researchers have expanded on these findings investigating SISE's relationship to clinician willingness to treat client sexual concerns. Clinical psychology students were found to engage in a higher number of sexual interventions with adult clients, exhibiting a willingness to treat client sexual concerns, when the clinicians indicated higher levels of skills self-efficacy and information self efficacy, two of the three components of SISE (Miller & Byers, 2010).

It is possible that the same constructs that inhibit mental health clinicians' willingness to work with sexual concerns for adult and adolescent clients, little sexuality-specific education and training, low DoS, and low SISE (Heiden-Rootes et al., 2017; Miller & Byers, 2008, 2010, 2012), may contribute to the overall lack of willing mental health clinicians who can effectively provide treatment to children who exhibit PSB in the community. The present study addresses a current academic gap, identifying what factors are related to and impact community mental health clinicians' willingness to work with children who exhibit PSB. This information will help the academic community better understand barriers to PSB treatment in children. Further research could focus on strategies to minimize some of the identified barriers, which could lead to an increase in access and engagement with PSB treatment for clients and their families. Having access to early and effective treatment is crucial to address our rates of child-on-child sexual abuse. Currently, rates of CSA are increasing, causing a strain on the public health and human service industries resulting in a potential limitation in their ability to respond

timely and effectively to victims of CSA (Jenkins et al., 2020). This suboptimal system response can result in further system traumatization of the CSA victims and their families, placing even further long-term strains on our public systems of support.

Purpose of the Study

The purpose of this study was to examine willingness among mental health clinicians to treat children 12 and younger who exhibit PSB as well as identify variables that have unique and combined relationships with mental health clinicians' willingness to treat children who exhibit PSB. I conducted a quantitative non-experimental survey research design to examine the unique and combined relationships between the predictor variables (DoS, SISE, sexual comfort, and sexuality-specific education and training) and the outcome variable (willingness to treat children age 12 and younger who exhibit PSB). A multiple linear regression analysis was conducted to evaluate the predictor variables' combined effect on the outcome variable. This analysis allowed the identification of those variables that are associated with either an increased or decreased mental health clinician willingness to treat PSB in children.

Research Question and Hypothesis

I investigated one research question and hypothesis. To measure mental health clinicians' level of DoS, I used the Differentiation of Self Inventory-Revised (DSI-R) (Skowron & Friedlander, 2003). The DSI-R has four dimensions including Emotional Reactivity, I Position, Emotional Cutoff, and Fusion with Others. To measure mental health clinicians' SISE, I used the Sexual Intervention Self Efficacy Scale (SISES; Miller & Byers, 2008). The SISES has three dimensions, including sex therapy skills subscale

(skills self-efficacy), relaying sexual information subscale (information self-efficacy), and sexual comfort/bias subscale (comfort self-efficacy). To measure mental health clinicians' amount of sexual comfort, I used the Sexual Comfort Scale (SCS; Harris & Hays, 2008). To measure clinician willingness to treat children ages 12 and younger who seek treatment for PSB, I used the Willingness to Treat Sexual Issues Scale-Revised (WTSI-R; Miller & Bryers, 2008). All other variables were measured using the demographic questionnaire created for the purpose of this study.

Research Question and Hypotheses

RQ 1: What is the extent of the combined and unique relationships between mental health clinicians' DoS measured by the DSI-R, SISE, measured by the SISES, sexual comfort measured by the SCS, and amount of sexuality-specific education and training, to the mental health clinicians' willingness to provide treatment to children who exhibit PSB as measured by the WTSI-R?

H₀1: There are not significant combined and unique relationships between DoS, SISE, sexual comfort, and sexuality-specific education and training that affect mental health clinicians' willingness to treat children ages 12 and younger who present to treatment for PSB.

H₁1: There are significant combined and unique relationships between DoS, SISE, sexual comfort, and sexuality-specific education and training that affect mental health clinicians' willingness to treat children ages 12 and younger who present to treatment for PSB.

Theoretical and Conceptual Framework

The theoretical framework for the present study is based upon two major psychological theories: Bowen's family system theory (Kerr & Bowen, 1988) and Bandura's 1997 theory of self-efficacy. The primary theory identified in the academic literature related to the present study topic is the theory of DoS, which is a construct based in Bowen family systems theory (Kerr & Bowen, 1988). Bowen's theory is a theory of human behavior that looks at the family (or any relationship group) as an emotional unit and applies the systems theory lens to explain complex interactions within the relationships (Kerr & Bowen, 1988). The theory posits that these relationships or units can be interdependent on a spectrum depending on an individual's level of DoS. DoS refers to the degree in which someone can intentionally regulate their emotions and respond in a non-reactive manner to another's behavior (Heiden-Rootes et al., 2017). Individuals with low DoS are more likely to demonstrate interpersonal fusion, to exhibit higher levels of emotional reactivity, and to have a limited ability to self soothe (Heiden-Rootes et al., 2017). In contrast, individuals with high DoS are likely to stay connected to others despite differences and can be intentional about how they regulate their emotional response while thinking through how they would like to respond interpersonally (Heiden-Rootes et al., 2017).

The DoS theory could partially account for why mental health clinicians may not be willing or able to effectively work with children ages 12 and younger who exhibit PSB. Previous research has found that the therapeutic relationship may function in a similar manner to the emotional family unit, where mental health clinicians' level of DoS

can play a role in their sexual comfort (Heiden-Rootes et al., 2017). This may impact their ability to effectively work with children who exhibit PSB, as higher levels of DoS may allow mental health clinicians to treat children willingly and accurately with an unconditional positive regard as well as to have the potential to accurately differentiate developmentally normative sexual behavior from PSB. Mental health clinicians with low DoS may become emotionally reactive when reading through the intake of a client who is seeking treatment for their PSB (Heiden-Rootes et al., 2017). That clinician may attribute this to transference or countertransference, which may cause them to decide not to work with populations (Heiden-Rootes et al., 2017). Other clinicians may attempt to work with the PSB client but find they do not have success with engagement, as the client and their family did not perceive the clinician as non-judgmental with an unconditional positive regard for the client (Shields, et al. 2020). Both instances represent how this theory could account for a component of why mental health clinicians are not willing and able to effectively work with this client population. Bowen's theory does so as it focuses on the impact of interpersonal relationships or individual characteristics such as DoS and SISE on other variables, such as deciding to enter into a personal or professional relationship.

The second theoretical construct is based in Bandura's 1997 studies of self-efficacy in relation to mental health clinicians' work with clients in treatment. Initially, Bandura found that there is a causal relationship between self-efficacy and a willingness to engage in and persist at tasks. Over the course of the last four decades this finding has been widely validated within the field of psychology (Lent et al., 1986; Nevill & Schlecker, 1988; Soodak & Podell, 1994). Additionally, there is some evidence to

suggest that increasing a clinician's self-efficacy in a specialized skill set may increase their interest and willingness to use that skill set or work with a particular population (Heppner et al., 1996; Miller & Byers, 2012). The present study focused on the specialized population of children who exhibit PSB and therefore built on theories of self-efficacy to apply Bandura's work to mental health clinicians' SISE with this client population. SISE stems from the construct of general self-efficacy, which is a person's belief around whether they will be able to successfully complete a given task (Miller & Byers, 2012). The construct of SISE is the confidence that a clinician has in addressing client concerns that are sexual in nature. SISE has three components to it: skills, information, and comfort/bias self-efficacy (Miller & Byers, 2008). For a clinician to have high SISE they must be able to feel that they are able to present themselves as comfortable discussing sexual issues while being able to prevent personal biases from interfering in treatment; to feel that they can relay accurate information about sexual topics, and to be confident in their knowledge and ability to use sex therapy techniques (Miller & Byers, 2008). Previous studies have looked at this relationship when treating sexual issues in adult and older adolescent client populations (Miller & Byers, 2008). However, previous research has not addressed the construct of SISE's relationship to clinician willingness and effectiveness when treating children who present to treatment with PSB.

Chapter 2 provides a more in-depth review of the Bowen's family system theory (Kerr & Bowen, 1988) and Bandura's (1997) theory of self-efficacy. Both DoS and SISE are core elements to the present study. These constructs drove the need to use previously

developed questionnaires to measure and compare levels of these constructs to directly answer the research questions. These comparisons allowed the quantitative analysis of the extent of the relationship of DoS and SISE to mental health clinicians' willingness to treat PSB in children. These constructs also strongly impacted the identification of the predictor variables of the present study, as both constructs have been linked to variables such as sexual comfort, sexual education and training, and willingness to treat patients with general sexual concerns.

Nature of the Study

A quantitative non-experimental survey research design using multiple linear regression analysis was used to examine the extent of variable relationships and interactions between DoS, SISE, sexual comfort, and amount of sexual specific education and training on mental health clinicians' willingness to treat children ages 12 and younger who exhibit PSB. SurveyMonkey was used to recruit mental health clinicians nationwide. Once recruited via a recruitment email, participants completed an online informed consent and survey that included detailed demographic questions as well as measures of that participant's DoS, SISE, sexual comfort, and willingness to treat PSB in children (see Appendices A-C). Once collected, data were analyzed using SPSS. A multiple linear regression was performed after the data set was cleaned, screened, and all assumptions for the multiple linear regression were met. The information obtained from this study may be used to better understand what variables, or combined effect of variables, have on mental health clinicians' willingness to treat children who exhibit PSB. This may contribute to improved training, education, and supervision of mental health

clinicians that could increase mental health clinician willingness to treat this population, which would lead to increased access to care for children who exhibit PSB.

A non-experimental quantitative survey design best fit the research question as the research question sought to assess and compare preexisting qualities/demographics of mental health clinicians (DoS, SISE, sexual comfort, amount of sexual specific training, and willingness to treat PSB) to establish a foundational understanding of how these variables may be at play in the population. This was accomplished through a non-experimental survey design as it did not require manipulation of variables. Using this design allowed the recruitment of participants nationwide which was meant to increase this study's participant number, therefore increasing the power of the results and the generalizability as it reached clinicians across geographic areas in the United States. Lastly, this design is ideal for the posed research question because research-related PSB in child populations and the mental health clinicians who serve them is in its infancy. Previous studies have not addressed this direct concern. However, studies that have come close have used either a qualitative or mixed method design to begin to create a foundation for qualitative studies as their recommended next steps so that some generalization effects could be identified to effect changes in treatment and clinician education and training related to sexual issues in clients (Hanzlik & Gaubatz, 2012; Harris & Hays, 2008; Heiden-Rootes et al., 2017; Miller & Byers, 2010).

Definitions

Caseload size: The number of clients assigned to the mental health clinician at the time of taking part in the study.

Child PSB treatment experience: Whether the mental health clinician has provided treatment to children ages 12 and younger who present to services with PSB.

Child: Someone age 12 or younger (Taylor et al., 2020).

Differentiation of self (DoS): The degree to which an individual can balance emotional with intellectual functioning and closeness with independence in relationships with others (Bowen, 1978).

Gender identity: The way in which the participant identifies their gender presentation at the time of their participation in the study (male, female, or other) (Pryzgoda & Chrisler, 2000).

Licensure status: Whether the participant is fully licensed, an agency affiliated counselor or an associate license at the time of their participation in the study.

Licensure type: The type of license the participant currently holds: licensed marriage and family therapist, licensed professional counselor, licensed mental health counselor, or licensed clinical social worker.

Mental health clinician: A master's degree level therapist/counselor/behavioral health provider/clinician who provides any form of therapeutic treatment to a client or clients, including agency affiliated, licensed, and associate licensed professionals.

Post-graduation sexuality-specific training: How many trainings that included sexuality-specific training has the participant attended at the time of the study.

Problematic sexual behavior (PSB): Developmentally inappropriate or atypical sexual behavior (Friedrich et al., 1992; Friedrich et al., 1998).

PSB treatment experience: Whether the mental health clinician has provided

treatment to anyone aged 13 or over who present to services with PSB.

Self-efficacy: A person's belief around whether or not they will be able to successfully complete a given task (Miller & Byers, 2012).

Sex: Either of the two main categories (male or female) that humans are divided into based on their reproductive organs at birth.

Sexual comfort: A cognitive, affective, and behavioral response to sexuality (Graham & Smith, 1984).

Sexual intervention self-efficacy (SISE): The extent of the belief that a mental health clinician has that they are capable of performing the specific tasks of: Sex therapy skills, relaying sexual information, exhibiting comfort with sexual topics, and exhibiting personal bias with sexuality based topics (Miller & Byers, 2008).

Sexual trauma history: Whether the mental health clinician, their family members, or their friends have a history of experiencing or witnessing any form of sexual abuse including but not limited to sexual harassment, molestation, incest, or rape.

Sexuality-specific training in graduate school: How many courses containing sexuality-specific education did the participant take during their time in college.

Willingness to treat PSB: A mental health clinician accepting new clients who identify as seeking services to specifically address sexual issues (sexual problems, sexual orientation, sexual dysfunction, or sexual relationship dynamics) as well as a mental health clinician's willful engagement in the discussion of sexual issues during treatment (Harris & Hayes, 2008).

Assumptions

In this study, it was assumed that most mental health clinicians lack some level of willingness and effectiveness to work with children ages 12 and younger who present to treatment to address PSB symptoms. The WTSIS was used to measure mental health clinicians' level of willingness to treat PSB in children and this scale has some evidence to support its validity and reliability. It also was assumed that the sample of mental health clinicians that respond to the self-report questionnaire on SurveyMonkey are representative of mental health clinicians from the United States and included participants who are willing and effective at treating PSB in children ages 12 and younger as well as mental health clinicians who are not willing and able to provide effective treatment to children ages 12 and younger who exhibit PSB. An additional and primary assumption was made that DoS, SISE, sexual comfort, and amount of sexuality-specific education and training interact somehow to predict mental health clinician willingness to treat PSB in children. Lastly, it was assumed that the participants respond openly and accurately to all portions of the developed questionnaire including the demographics, DoS, SIES, SCS, and the WTSIS. It was necessary in this study to make the above assumptions to move forward with the research project as the first assumption had only been identified through qualitative research which recommended the next step to address the gap be a quantitative study to better identify if the assumption was accurate and mental health clinicians do feel unwilling or unable to provide effective treatment to children who exhibit PSB. The other assumptions listed are common and necessary to the social sciences when the study is not a true experimental design (McGrath, 2011) which

this one is not due to ethical dilemma with that as a possibility.

Scope and Delimitations

The present study addressed the research problem that there are currently not enough willing and effective mental health clinicians treating PSB in children ages 12 and younger to meet the client demand and to provide these clients with timely and appropriate access to care. Mental health clinician willingness to provide this treatment was the primary focus of this study. Willingness to treat PSB in children was identified as the outcome variable for the study. Previous research has identified that, collectively, mental health clinicians tend to avoid working with complex and uncomfortable topics such as sexuality. Additionally, previous academic literature has shown a significant correlation between mental health clinician willingness to treat sexual issues in adults and adolescents and the independent variables of DoS, SISE, sexual comfort, and sexuality-specific education and training. Furthermore, qualitative research has indicated that mental health clinicians report a lack of willingness to treat PSB due to feeling that they do not have adequate skills or the supervision necessary to provide effective treatment to this population. Several concepts that could apply to this study were not used within the theoretical framework as they were not supported by the current academic literature on this topic area. The primary example is the concept of avoidance. Although it is easy to see how mental health clinicians avoiding tasks that are difficult and uncomfortable could apply to the subject of working on sexuality-related issues with children, the concept of this did not appear anywhere within the current academic literature related to this topic.

Participant population of this study focused on mental health clinicians at a

master's level who are actively practicing counseling services within the United States. Exclusion factors were mental health clinicians outside of the United States, those who were not actively practicing at the time of the study recruitment, clinicians with fewer than 6 months of clinical experience working with clients ages 17 and younger, and clinicians who were actively practicing but were doing so at the bachelor or doctoral level. Inclusion criteria were that participants had to be an actively licensed mental health clinician with either a full or associate license, they have a minimum of 6 months of clinical experience working with youth ages 17 and younger and that participants live and practice within the United States at the master's level. The study's results are generalizable to other mental health clinicians at the master's level actively practicing counseling within the United States. However, this generalization of any results should be done with caution as the current study is a non-experimental design with convenience sampling, limiting its ability to be generalized to the population at large (McGrath, 2011).

Limitations

As with most research in the social sciences, this study has several limitations that should be considered when reviewing its results, applications, and conducting future research based primarily on this study. The limitations include the use of a convenience sample, the use of self-report survey questionnaires as the primary source of data collection, and the possibility that other confounding variables exist but were not identified in the academic literature reviewed in the preparation for this study.

Convenience sampling limits the generalizability of the study to individuals who participate within the study. In this case, as this is a foundational study that is the first

quantitative study on this topic, the lack of generalizability is less problematic as it may still provide crucial new information to the furthering of this subject. The use of convenience sampling also helped to alleviate a potential ethical issue of researcher bias as there was no direct contact with the participants and the participants came from areas across the United States, increasing participant anonymity. The potential for bias was due to me previously working the field of specializing in the treatment of children who exhibit PSB as well as providing training and supervision to mental health clinicians beginning to learn and foster competencies in this area.

The use of self-report questionnaires is a common practice within the field, and although it is a potential limiting factor, it is the natural next step to the development of this research area as all previous studies focused on foundational qualitative information gathering. This method of data collection, however, does make it possible for inaccurate self-report information to be provided by participants due to the sensitive nature of the subject matter. Lastly, there is always the possibility of existing confounding variables, but this limitation has been mitigated as best as possible by constructing the study variable based on the current literature as well as by the inclusion of an extensive demographic questionnaire where additional statistical analysis was performed to assess for this as an issue with any results (McGrath, 2011).

Significance

This study contributes to the knowledge in this field, especially as it relates to the treatment of children who exhibit PSB. Quantitative information gained in this study is the first of its kind, collecting nationwide statistics and data on mental health clinician

willingness to treat this population while evaluating what contributing factors may increase or decrease the likelihood of future graduate students to be better prepared for willingness to work with this population once in practice. Demographics collected also provide insight on the rates with which clinicians are treating this issue across a variety of treatment settings, degree, and licensure types. Lastly, new geographical comparisons can be made due to the geographic breadth of the study being nationwide. These results provide a foundation to be built on in order to make beneficial changes to policy and practice as it relates to the education, training, and supervision of mental health clinicians in order to create systemwide and practice changes that facilitate the fostering of clinician development toward unconditional positive regard toward all clients that occurs once mental health clinicians have the knowledge, resources, and skillset to effectively treat children with PSB.

Potential implications for positive social change include increasing child access to effective treatment for PSB. With this increase in access to early identification and treatment of PSB, there is the potential that these clients will get the support they need early in the development of their PSB, which could help reduce the overall rates of child-on-child sexual abuse as well as the development of children with PSB from continuing to act out in this way. This also could ultimately decrease the numbers of adolescent and adult individuals who perpetrate CSA, again reducing rates of childhood sexual victimization. This reduction in CSA victims could allow the public health and human service industries within the United States to have a decreased volume of children to support after experiencing CSA, which would allow for those children experiencing CSA

to have timely, effective, and trauma-informed responses from these support systems. This could result in an overall healthier and safer society for generations to come.

Summary

The lack of ability for children ages 12 and younger to find and obtain effective treatment from willing and competent mental health clinicians to address their PSB symptoms is a significant social problem that affects a variety of disciplines from public health to juvenile justice. Developing a community mental health and graduate education system that helps to foster the growth of willing and effective mental health clinicians treating PSB in children would increase access to early treatment and intervention for these presenting problems which if left unaddressed may develop into more serious ingrained community safety concerns with increased rates of CSA. For the development of this system to be possible, the academic community must gain a better understanding of the factors that positively and negatively impact mental health clinicians' willingness and ability to work with PSB in children 12 and younger. Bowen's family system theory and DoS identifies one possible contributing factor to decreased clinician willingness to treat emotionally charged or taboo areas, as it suggests that clinicians with low DoS may not be able to successfully differentiate their emotions related to the therapy content during sessions. Bandura's theory of self-efficacy, later evolving into SISE, also provides foundational information related to how clinicians cannot effectively or confidently engage in this work without first gaining competencies in the subject matter, which is currently sorely lacking in our nation's graduate programs as well as in postgraduate intervention trainings. Other possible contributing factors to mental health clinician

willingness may include sexual comfort and sexuality-specific education and training, which may also be connected to the two main theoretic constructs of the study, DoS and SISE.

In Chapter 2 a short restatement of the study problem and purpose is provided. The focal point and primary function of the chapter is to provide an exhaustive review of the current and historical academic literature related to the topic of this study as well as its surrounding areas of study. This includes academic literature related to PSB, CSA, DoS, SISE, sexual comfort, and sexuality-specific education, training, and supervision across a variety of disciplines. In addition, this chapter provides clear details related to the library search strategies employed to obtain the reviewed literature in the chapter, an explanation for the chosen conceptual framework and theory, as well as a summary and conclusions of the overarching themes of the chapter.

Chapter 2: Literature Review

Current research findings show that PSB is an increasingly prevalent mental health issue, especially among children and younger (Malvaso et al., 2019). With this clinical client population on the rise, it is important that there are enough mental health clinicians in the community who are willing and able to effectively treat this client population. However, currently there are two significant barriers to these clients being able to successfully complete treatment: (a) clients and their families are often unable to locate specialized treatment providers who address PSB in their community, and (b) clients and families often do not feel that they receive the same unconditional positive regard and non-judgment that other non PSB clients receive from their treating mental health clinician (McKibbin, 2017; Shields et al., 2020; Shields et al., 2018). Further research was warranted to explore the factors that contribute to the lack of willing mental health clinicians in community mental health agencies that can effectively provide treatment to children who exhibit PSB. A better understanding of what factors contribute to mental health clinicians' willingness to provide treatment to children who exhibit PSB may help graduate training programs, community mental health agencies, and child advocacy centers target the education of new clinicians to focus on factors that may facilitate their willingness to work with this increasing client population.

The purpose of this quantitative study was to examine the relationship between mental health clinicians' levels of DoS, SISE, sexual comfort, amount of sexuality specific education and training, and their willingness to provide treatment to children who exhibit PSB. In Chapter 2, the literature search strategy, theoretical framework, and

literature review are discussed. The chapter concludes with a summation of critical points.

Literature Search Strategy

The literature search for this study was conducted by accessing resources available online through the Walden University research databases, including Psych ARTICLES, ProQuest Central, PsycINFO, ScienceDirect, and Taylor & Francis Online. The keywords searched were *literature review, systematic review, problematic sexual behavior, problematic sexualized behavior, sexual behavior problem, maladaptive sexual behavior, working, treatment, treating, children or adolescents or youth or child or teenager, clinician or therapist or counselor, sexual comfort, prospective or perceptions or ideas or opinions or views, education or training, burnout, willingness or comfort or confidence, and differentiation of self*. The focus of research articles selected related to CSA, PSB, DoS, SISE, sexual comfort, mental health clinician training and education related to sexual issues, and mental health clinician willingness to work with clients who present with sexual issues. The literature selected included full-text articles on the above topics that have been published within the last five years (2017-2021), as well as several pivotal historical articles related to theoretical framework.

Theoretical Foundation

The construct of DoS is based in Bowen's family systems theory (Kerr & Bowen, 1988) and provides a foundation for this research study. Bowen's theory is one of human behavior that looks at the family (or any relationship group) as an emotional unit, and then applies the systems theory lens to explain complex interactions within the

relationships (Kerr & Bowen, 1988). The theory posits that these relationships or units can be interdependent on a spectrum depending on individuals' level of DoS. DoS refers to the degree in which someone has the ability to intentionally regulate their emotions and respond in a non-reactive manner to another's behavior (Heiden-Rootes et al., 2017). Individuals with low DoS are more likely to demonstrate interpersonal fusion, exhibit higher levels of emotional reactivity, and have a limited ability to self soothe (Heiden-Rootes et al., 2017). In contrast, individuals with high DoS are likely to stay connected to others despite differences and can be intentional about how they regulate their emotional response while thinking through how they would like to respond interpersonally (Heiden-Rootes et al., 2017).

Previous research has found that the therapeutic relationship may function in a similar manner to the emotional family unit, where mental health clinicians' level of DoS can play a role in their sexual comfort when addressing sexual issues with clients (Heiden-Rootes et al., 2017). This may ultimately impact their ability to effectively work with children who exhibit PSB as higher levels of DoS may allow them to accurately differentiate developmentally normative sexual behavior from PSB. The DoS theory could partially account for why mental health clinicians may not be willing or able to effectively work with youth who exhibit PSB. Mental health clinicians with low DoS may become emotionally reactive when reading through the intake of a client who is seeking treatment for their PSB (Heiden-Rootes et al., 2017). That clinician may attribute this to transference or countertransference, which may cause them to decide not to work with populations (Heiden-Rootes et al., 2017). Other clinicians may attempt to work with

the PSB client but find they do not have success with engagement, as the client and their family did not perceive the clinician as non-judgmental with an unconditional positive regard for the client as a result of their unregulated emotional response to the client's reported behaviors (Shields, et al. 2020). Both instances represent how this theory could account for a component of why mental health clinicians are not willing and able to effectively work with this client population.

SISE is a second foundational construct based in Bandura's 1997 studies of self-efficacy in relation to mental health clinicians' work with clients in treatment that may play a role in better understanding the research questions at hand. Initially, Bandura (1997) found that there is a causal relationship between self-efficacy and a willingness to engage in and persist at tasks. Over the course of the last four decades this finding has been widely validated within the field of psychology (Lent et al., 1986; Nevill & Schlecker, 1988; Soodak & Podell, 1994). Additionally, there is some evidence to suggest that increasing a clinician's self-efficacy in a specialized skill set may increase their interest and willingness to use that skill set or work with a particular population (Heppner et al., 1996; Miller & Byers, 2012). The present study focused on the specialized population of children who exhibit PSB and therefore built on theories of self-efficacy to apply Bandura's work to mental health clinician's SISE with this client population.

SISE stems from the construct of general self-efficacy, which is a person's belief around whether they will be able to successfully complete a given task (Miller & Byers, 2012). The construct of SISE is the confidence that a clinician has in addressing a client's

concerns that are sexual in nature. SISE has three components: skills, information, and comfort/bias self-efficacy (Miller & Byers, 2008). This means that in order for a clinician to have high SISE they must be able to feel that they are able to present themselves as comfortable discussing sexual issues while being able to prevent personal biases from interfering in treatment. They must also feel that they have the ability to relay accurate information about sexual topics. Finally, they must be confident in their knowledge and ability to use sex therapy techniques (Miller & Byers, 2008). Previous studies have looked at this relationship when treating sexual issues in adult and older adolescent client populations (Miller & Byers, 2008). However, previous research has not addressed the construct of SISE's relationship to clinician willingness and effectiveness when treating children who present to treatment with PSB.

Literature Related to Key Variables

CSA

The scientific community has long been aware of the complex construct of CSA and its impact on the community across various professions such as child welfare, law enforcement, education, child advocacy, community mental health, juvenile justice, and medical centers. Therefore, in most countries, such as the United States, Australia, and the United Kingdom, CSA is currently seen as an issue of public health (Malvaso et al, 2019). As an identified public health concern in recent decades, researchers have turned their attention to understanding the etiology of CSA in order to have a more comprehensive view of who commits CSA and how their developmental pathway leads them to engage in such acts (McKibbin & Humphreys, 2020). Although prevalence rates

for who commits CSA widely vary, due to the complex nature of obtaining accurate reporting on this topic, several studies have documented that anywhere from 30% to 65% of CSA is committed by other children and adolescents. For example, Shlonsky et al. (2017) identified children and adolescents as responsible for a substantial amount of Australia's documented CSA. Radford et al. (2011) found that more than 65% of CSA in the United Kingdom was committed by children and adolescents. Finkelhor et al. (2009) found that over 30% of CSA in the United States is committed by this same subset of the population. These prevalence rates contradict the general public's conception that CSA is primarily committed by adult strangers (Krienert & Walsh, 2011).

The statistical prevalence of CSA committed by children and adolescents has identified a need for a better understanding of children who commit CSA as they appear to contribute to the overall public health issue. Past studies have hypothesized that early and successful intervention with these children could help reduce rates of CSA as a whole (Jenkins et al., 2020). One of the current treatments being researched as an evidenced based practice for these youth, cognitive behavioral therapy for PSB (CBT-PSB), has shown results approaching statistical significance for children who successfully completed the therapeutic intervention, when looking at reducing future instances of CSA (Jenkins et al., 2020). To better understand the need for successful treatment of children who commit CSA, it is necessary to conceptualize and define this population of children, the etiology of their behavior, and environmental circumstance.

PSB

Children under the age of 12 who act out in a sexually atypical or problematic

way are labeled in the research as children who exhibit PSB. It is important to note that although children who exhibit PSB are a subset of the population, decades of research around child development and sexuality have established that most childhood sexual behavior is typical and developmentally appropriate (Friedrich et al., 1992; Friedrich et al., 1998). Chaffin et al. (2008) defined children who exhibit PSB as “children ages 12 and younger who initiate behaviors involving sexual body parts (i.e. genitals, anus, buttocks, or breasts) that are developmentally inappropriate or potentially harmful to themselves or others” (p.200). PSB is a spectrum of behavior with a large degree of variance between children and can be both self-directed in nature (i.e., excessive masturbation or pornography use), or interpersonal in nature, meaning that it is directed toward other youth (sexually intrusive or aggressive behaviors) or those that imitate adult behavior (e.g., attempted intercourse, oral-genital contact, insertion of objects into the vagina/rectum; Friedrich et al., 1991, 1998; Malvaso et al., 2019). Interpersonal PSB may be its own subset of PSB that requires more direct research, as it is more likely to have a greater degree of impact or harm to others due to their potential to result in CSA (Allen, 2017).

Unlike adult sexual behavior that results in CSA, which mainly stems from the seeking of sexual gratification, PSB in children is known to result from curiosity, anxiety, a child’s own experience of CSA, or imitating/modeling observed adult behavior (Chaffin et al., 2008; Silovsky & Bonner, 2003). This holds true for both self-directed and interpersonal PSB in children. Wamser-Nanney and Campbell, (2019) conducted a study of 254 children from the ages of 2 to 12 who reported instances of CSA through child and

caregiver self-report. They concluded that children who reported CSA and who had higher rates of post-traumatic stress symptoms were more likely to engage in future self-directed PSB in comparison to their low post-traumatic stress symptoms counter parts. It was also found that participants who were boys, younger children, experienced a greater severity of their own CSA, and had higher post-traumatic stress symptoms were more likely to develop interpersonal PSB directed toward others. These results indicate the need to identify children with these characteristics and provide them with effective early treatment intervention as to potentially reduce the risk of them developing or maintaining PSBs.

PSB Treatment Access

Client and Family Perspective on PSB Treatment Access and Effectiveness

Although children exhibiting PSB has been a mental health issue that could benefit from specialized early intervention via clinical treatment, much of the specifics related to treatment intervention development are unknown or still under development (Shields et al., 2020). As with any other specialized areas of clinical treatment, it is important to better understand the interventions related to PSB in children that have been provided thus far in the field's development. This understanding can help improve treatment delivery and outcomes. Ultimately, doing so provides an opportunity to improve the client and family experience while having the potential to reduce community safety issues related to PSB recidivism. Several recent studies have looked at both client and family perspective related to PSB treatment and interventions and community support/response following the identification of the PSB.

Shields et al. (2020) conducted a retrospective mixed methods study of 30 male young adults, ranging in age from 18 to 30, from North America, South America, Europe and Australia who identified as having a sexual interest in children that began in their childhood and adolescent years of development. The sample population was reportedly made up of a non-forensic participant pool that was not currently experiencing legal involvement related to their PSB. More than half of the sample reported that their PSB was in the past and the remainder of the sample reported that they were “non-offending,” meaning that they reportedly had never acted out on their problematic sexual interests at the time of the study. The objective of the study was to gain more understanding of adolescents and young adults with problematic sexual interests in order to better direct prevention and treatment efforts related to PSB.

Grounded theory was used to conduct phone interviews with each participant, who were also asked to complete a brief online questionnaire. Results indicated that most participants identified their sexual interest in younger children as emerging during their own childhood and adolescence. During this time, they reported a mixture of negative emotions including shame, fear, and isolation. Participants in the study noted that having support from community programming, family, and a positive role model who they could be open with related to their problematic sexual interests while supporting their safe and healthy navigation of their PSB would have been beneficial to them. These are all items that are typically able to be addressed during the course of standard PSB treatment. Shields et al. (2020) concluded that adolescents and young people with problematic sexual interests or a history of PSBs continue to remain unseen and vulnerable, even as

some seek help, support, and treatment related to safely navigating their sexuality. Limitations of the study were named as a small minimally generalizable population, as the majority of participants were white males from North America. Despite this and other notable limitations, the takeaway from this study was best described in the words of participant 184: “I remember as an adolescent myself, even searching for these things, looking them up online, I couldn't find anywhere that I could go besides going and paying for a professional psychologist to talk and even then, I knew that there would be a number who wouldn't know what to do with this particular situation. I feel like if information was more publicly available about where to go, including things like online support groups, things like the benefits of finding a close, trustworthy friend to talk to... if adolescents were taught about that kind of thing, then I feel like a lot more would have a better chance of finding support”. This participant’s quote mirrored many others from the study who reported a lack of support with the topic of PSB by family, professionals, and the community, with an extra emphasis being placed on the fact that they were unable to identify professionals in the field who specialized in the area of PSB and presented themselves as safe and non-judgmental resources for PSB treatment (Shields et al., 2020).

A previous study conducted by Shields et al. (2018) explored family perspectives on treatment services for children who exhibit PSB. This study took a qualitative approach at examining the consumer (client and family) impressions of PSB treatment services, including participants’ perception of treatment impact, support, and barriers. Following the successful completion of Cognitive Behavioral Therapy for PSB, 149

caregivers and 144 clients completed an exit survey related to their treatment. Qualitative data was also collected by conducting 30 caregiver interviews in order to gain further information related to their experiences with the PSB-specific treatment.

Results indicated that both the caregivers and children found that the treatment met their initial treatment expectations of increasing their knowledge and skills, healthy family communication, healthy client behavior, and increased social supports. However, clients and caregivers made several recommendations that included increasing PSB-specific service availability and accessibility, as well as making programming improvements that would better engage the clients and families in services sooner through a non-judgmental stance in treatment by the providers. Limitations in this study were that it only looked at participants who successfully completed treatment and therefore did not evaluate the perspectives of individuals who need PSB treatment but who did not complete it or who were unable to access it. Overall, Shields et. al, (2018) view this as a foundational study in the area of PSB treatment and family engagement in services. The study recommends further research, including youth interviews of their perspective of the treatment process, implementation of PSB treatment across the United States to make it more accessible to children and families, requiring its focus and further research into the intricacies of successfully engaging clients and their families in PSB specific treatment (Shields et al., 2018).

Treatment Providers' Perspective of PSB and Client Sexual Concerns

In addition to understanding client and family perspectives of PSB treatment, several studies have sought to obtain the perspectives of treatment providers working

with clients presenting to treatment for PSB or other sexual concerns. As PSB treatment, especially in children ages 12 and under, is an underdeveloped area of study (Heiden-Rootes et al., 2017) this foundational understanding of mental health clinicians' perspectives helped begin revealing how these clinicians treat and conceptualize clients who present for PSB treatment (Short et al., 2016). In addition, this information helps identify some potential barriers for mental health clinicians being willing and able to provide effective treatment to PSB clients.

Short et. al. (2016) conducted a quantitative study with 183 mental health providers (LMHCs, LMFTs, and psychologists) looking to assess how issues of sex addiction, problematic pornography use, PSB, and other sexual concerns present to these providers while looking at how these providers diagnose, conceptualize, and treat these clients in their practice. Data was collected over a 15-month period through both in-person and online recruitment where participants were asked to complete self-report questionnaires made up of fill-in-the-blank and Likert items, requiring around 30 minutes of participants' time. Survey questions consisted of demographic information, including items related to licensure and education/training, as well as items related to the provider's beliefs and experiences treating clients with PSB. Results indicated that most providers have treated clients presenting to treatment for PSB while feeling they were not competent to treat these clients. Providers who endorsed being specialized PSB treatment providers reported higher feelings of competency in treating PSB compared to non-specialized providers. Out of the participant sample, 5.5% of providers reported being PSB specialists. Short et. al. (2016) found that treatment issues reported by the clinician

participants included the diagnostic ambiguity of PSB, lack of provider and academic research knowledge related to PSB, and a limited dissemination of the existing research related to PSB all as potential barriers to providers being able to effectively treat and assess clients presenting for treatment of PSB.

In Short et. al.s' (2016) study one of the researchers' assumptions was related to the limitations surrounding the skewed data results as the data would have a minimal ability to be generalized, due to the inclusion of numerous provider types in the sample population type (providers working with adults, adolescents and children), versus a study that focused on a singular provider type, i.e. providers who work with one specific developmental subset of PSB clients. The second identified study limitation was noted that the results may not represent the prevalence of PSB in the whole population as it inquired specifically about clients who exhibit PSB and present to treatment (Short et al., 2016). The study concluded that PSB issues appear frequently in clinical populations and results indicate that assessment, treatment, and training are not adequate to provide PSB clients with effective treatment. Short et. al. (2016) reported an important need identified in the study was for further education and training of mental health clinicians in the specific areas of PSB treatment, symptom identification, function of PSB symptomology, and comorbid diagnostics. Further research seeking a more in-depth understanding of the characteristics and treatment of PSB is called for by Short et. al, (2016)

Training and Education on Sexual Issues

As specialized training and education was named by Short et. al. (2016) as a need for mental health clinicians for them to be able to provide effective treatment to

individuals presenting to treatment for PSB related concerns further review was done surrounding the academic research in the area of mental health clinician sex education both during and post graduate training. Hanzlik & Gaubatz (2012) conducted a quantitative cross-sectional study with 138 Clinical PsyD trainees to investigate their comfort level discussing sexual topics with clients. A self-report questionnaire was used to assess participants' comfort level when addressing a variety of sexual topics and concerns with clients. Results indicated that, overall, participants reported lower comfort appraisal scores when discussing a client's specific sexual issue compared to higher comfort appraisal when discussing global sexual topics with clients. It was also found that female participants reported significantly less comfort discussing sexual issues with male clients compared to their male participant counterparts. Participants' previous sexuality training and attitudes correlated positively with comfort discussing sexual client concerns and participants' general training and clinical experience did not show any correlation. According to Hanzlik & Gaubatz (2012) this was interpreted as representing a need to incorporate sexuality and PSB client issues into general masters and doctoral level graduate programs to possibly increase provider comfort in treating clients who present to treatment with sexual concerns.

An important study limitation mentioned was that participants' previous sexuality-specific training was categorized dichotomously as either "no previous training" or as "had previous sexuality specific training". Hanzlik & Gaubatz (2012) also noted that the study looked at a "snapshot" in clinician development and did not assess the future effects of clinicians' sexuality training on PSB client care. The researchers

concluded that it is important to instill mental health professionals with the ability to discuss topics of sexuality in a therapeutic setting with ease. This suggests that without such specific training on sexuality and sexual issues, mental health professionals will not be fully comfortable addressing clients' sexual treatment concerns and PSB issues in treatment (Hanzlik & Gaubatz, 2012).

Taylor et al. (2020), conducted a qualitative study exploring the perceptions of various provider types across disciplines (school staff, child welfare, juvenile justice, and mental health providers) who work directly with youth who exhibit PSB. The aim of the study was to better understand how professionals working with this population perceive and conceptualize PSB and online sexual behavior, as there has been very limited previous research in the area. To explore this issue Taylor et al. conducted semi-structured telephone interviews with 36 professionals across 8 different sites. During the interviews participants were asked about their views of youths' use of technology, changes in the youths' use of technology and online sexual behavior, severity, frequency, and impact of the PSB they observe, and the community response to PSB.

Participants indicated that youths' online PSB are frequent, on the rise, and concerning. However, the participants also report that they lack protocols to effectively assess the severity of the online PSB, as well as any education, evidenced based practice, or training to guide their response to the online PSB youth are presenting with (Taylor et al., 2020). Two main study limitations were noted by the authors that included the limited breadth of the study, as they only asked 5 semi-structured interview questions to keep interviews under 1 hour in length. The second limitation noted that both law enforcement

and school professionals were two underrepresented professional groups in the participant pool, which may have skewed results being more indicative of the child welfare and mental health professional viewpoint. Future research was recommended to use larger samples that were more inclusive of law enforcement and school professionals, as these groups hold what is hypothesized to be large roles in interactions with youth who exhibit PSB. Taylor et al. (2020) discussed larger implications of the findings to be that a multi-systems approach is warranted to best promote healthy youth development and effectively address youths' online PSB through policy, school practices, and changes to professionals'/family training and education in this area (Taylor, Slemaker, & Silovsky 2020).

Miller and Byers (2010) conducted a quantitative study assessing 162 Canadian psychologists in an effort to better understand what sexuality training and education they received during their graduate education, practicum, and internship. This was assessed using online questionnaires that covered topics of demographics, sexual intervention education and training, verbal persuasion, sexual conversation, and sexual communication comfort. Participants indicated that they had received some education related to human sexuality; however, it was reported to be severely limited in depth and scope. The amount of training and education in this area was not correlated to the length of time the psychologists had been in practice, and it was therefore concluded that most participants attained their sexuality-related training during their time in graduate school. Education around healthy sexuality was reported as being even more limited than the education received related to PSB during the psychologists' graduate training. The

amount of direct sex therapy provided to clients by participants was predicted by the amount of sexual-specific training experiences participants had.

Limitations of this study relate to its lack of generalizability to other populations, as this study explicitly assessed psychologists in Canada, which is not the primary population of mental health clinicians who work with individuals who exhibit PSB (Short et. al, 2016). However, one might infer that psychologists' training and education is more rigorous than the typical mental health clinician or clinical social worker, who may more frequently provide treatment to clients for PSB. This presents some concern as the present study determined that this population's sexual-specific education and training is already very limited in depth and scope. Ultimately, Miller and Byers (2010) concluded that most psychologists get what limited training they have on sexuality and PSB during their time in graduate school and that the more specific training they receive in this area the more they will treat clients with PSB or sexuality issues. This conclusion had the authors calling for more comprehensive sexually-specific education and training for graduate students, which they felt may contribute to more clients' receiving effective treatment when presenting to services for these specialized issues (Miller & Byers, 2010).

DoS

An additional factor that may play a role in clients having access to effective treatment for PSB is mental health clinicians' level of DoS. Although previous studies have noted that individual differences such as a clinician's gender or age are not determining factors in their willingness to treat clients who exhibit PSBs (Miller & Byers, 2010) there have been few investigations into whether or not trait-based factors versus

the previously named demographic constructs may be contributing factors in a clinician's ability to use their sexuality-specific training with clients in an effective manner. To date there has only been one study that investigated the role of DoS related to clients presenting to treatment for sexual concerns (Heiden-Rootes et al. 2017), which hypothesized that a better understanding of this issue may help illuminate the relationship between clinicians' discomfort with sexuality in treatment and its impact on their perceptions of clients' sexual behavior as problematic (Heiden-Rootes et al., 2017). For example, if DoS has an impact on clinicians' perception of sexual behavior being problematic, this has a clear link to clients being able to access effective treatment as those clinicians could complete PSB client assessments inconsistently. Some clinicians with high levels of DoS could lean towards minimization of PSB symptoms, screening clients out of service who need it, where other clinicians with low levels of DoS may screen clients into treatment who do not need it, overestimating the sexual behavior as problematic, resulting in inconsistent access and ineffective treatment administration.

Heiden-Rootes et al's (2017) flagship study on this topic sought to evaluate the role of DoS on clinicians' sexual discomfort related to their perception of client sexual behavior as problematic. A mixed methods study with 198 mental health clinicians from across the United States was conducted asking participants to respond to self-report questionnaires on DoS, sexual comfort, personal values, and demographic information following their review of a vignette of a client presenting to treatment for sexual concerns. They found that clinicians' ratings of sexual behavior as problematic varied as a function of their level of DoS. Clinically, results indicated that clinicians high in DoS

levels will be more comfortable when working with clients on topics of sexuality and clinicians with lower levels of DoS are likely to be less comfortable with topics of sexuality and more likely to assess the sexual behavior as problematic. Clinicians with lower levels of DoS were also noted as having more frequent dysregulation, needing more reflective processing when training related to sexuality was engaged in.

The study was noted to have several limitations according to Heiden-Rootes et al. (2017). These limitations were noted as a lack of generalizability due to the sample of clinicians being predominately white females; the lack of collection of longitudinal data given the cross-sectional nature of the study; and limited interpretive quality of the self-report sexual comfort measure used, as the measure was noted not having its construct validity being validated. All of these aspects were issues the authors recommended be improved upon for future studies in this area. In addition to these study improvements, future research related to looking at other individuals presenting to treatment such as couples, adolescents, and children, as the present study only presented vignettes related to heteronormative adults presenting to treatment with sexual concerns. Heiden-Rootes et al. (2017) concluded that clinicians are reporting an increasing number of clients presenting to treatment for sexual concerns yet they feel uncomfortable and underprepared to work with this client issue. It is hypothesized that due to these feelings clinicians are more at risk to treat clients PSBs subjectively (through impact of their own sexual comfort, sexual values, and characteristics). It was found that clinicians' impacted perception was a function of their DoS level. The authors proposed that DoS may be used in mental health professionals' training and education programs to give language and theory related to

discomfort and biases to sexuality-based topics for clinicians in training for them to be better prepared for this clientele who present to treatment.

SISE

Miller & Byers (2010) were also interested in investigating the effects of clinicians' traits and individual differences when providing treatment to individuals presenting with sexual issues, particularly the clinicians' willingness to provide treatment to this client population. Their study looked closely at SISE or the clinician's confidence in their ability to address sexual issues. A model of how sex education and training affect clinicians SISE was assessed in this quantitative study. Participants were 110 American and Canadian Psychologists who had completed their graduate programs and were more than 1 year post graduation. They were recruited online through psychology listservs to complete online self-report questionnaires. SISE questionnaires looked at three subsets of SISE: 1) Skills Self-Efficacy, 2) Information Self-Efficacy, and 3) Comfort/Bias Self-Efficacy. Results indicated that participants particularly lacked Skills and Information Self-efficacy—the ability to address and provide accurate information to clients in relation to their sexual concerns. Participants also reported that they did not routinely ask clients about topics of sexuality or PSB. It was found that the more sexual-specific education and training a participant had in graduate school, the more likely they were to seek out additional training in this area following their program's conclusion. As hypothesized, the more sexual education and training reported by participants, the higher their levels of Skills and Information SISE were reported. The higher rates of SISE in these two areas also correlated with the number of clients served by the participants

related to sexuality-based presenting problems. Those with less sexual-specific training reported lower levels of Information and Skills SISE and saw fewer clients presenting with sexual concerns. However, sexual-specific training did not relate to increased levels of Comfort/Bias SISE, the clinicians' ability to appear comfortable and unbiased when addressing sexual issues with clients.

The limitations of this research were noted in several areas by Miller and Byers (2010). The primary limitation was identified as the study has a limited scope since it only evaluated psychologists and did not investigate other mental health professionals such as mental health clinicians, therapeutic aids, or mental health paraprofessionals. Although the researchers hypothesized that similar results would be present in the other subspecialties, no research to date has confirmed this. A second limitation that was identified was that the data collected primarily relied on the self-report memories of the participants, some of whom had been in the field for many years, increasing the likelihood that some of their self-report data was skewed. Finally, the researchers noted that the study participant response rate was low and the non-completion rate was high, likely due to the lack of compensation rate for participants and length of time needed for survey completion (30 to 50 minutes). Lastly it was noted that some of the measures used were newly created measures that had not been validated at that time and therefore could have been unreliable measures. Despite the numerous limitations of this study, they appear appropriate as this study appeared to be the first of its kind investigating SISE related to clinician willingness to treat PSB. Miller & Byers (2010) concluded that even the limited amount of sexual-specific education and training received by psychologists

appears to increase their confidence in addressing and providing information related to sexuality-based concerns and topics with clients as well as increasing their willingness to take on that role in treatment. This is encouraging as it gives some possible direction of how to increase clients' access to PSB services through increased clinician training related to sexuality-specific topics that may increase clinicians' SISE. This idea corroborates Bandura's 1997 study that showed an increase in clinician self-efficacy through increased education and training.

Sexual Comfort of Clinicians and Their Willingness to Treat PSB

The previous study by Miller & Byers (2010) reviewed SISE and how some aspects of it (Skills and Intervention Self-Efficacy) have a positive correlation with sexuality-specific training and education. However, that study indicated that the third component of SISE, Comfort/Bias Self-Efficacy, was not correlated to sexuality-specific training and education. The following historical and more recent studies will take a more in-depth look into mental health professional's relationship with sexual comfort. Anderson (1986) explored clinicians'-in-training sexual comfort level across the completion of their human sexuality course with him.

As this study is historical in nature it has significant limitations with not being current literature; however, it is helpful in providing a foundational theory for conceptualizing the sexual comfort of mental health clinicians. Due to its historic nature the qualitative research methods are minimal at best and the study explores the concept in a more theoretical manner, limiting its generalizability, validity, and reliability. Anderson (1986) was interested in better understanding clinician-in-training comfort level around

client sexuality across the time they spent in a human sexuality course with him. He theorized that the clinicians-in-training for sexuality-specific client topics would have developmental stages, and he assessed this through specific educational interventions he had been using across his teaching career (live demonstrations of clinical work with rape victims, practicing of sexual history taking with clients, lectures, sex therapist guest speakers, sex therapy rehearsal, sex journaling, sexuality based reading assignments and student group presentations around various sexual topics) and the examination of student kept sexuality logs detailing their perception of their course experience as well as their self-report of comfort levels at the end of the course. These student interventions were designed by Anderson (1986) in an effort to help clinicians become comfortable addressing clients' sexual concerns, as past research had indicated that clinicians require sexually specific training to become effective in working with clients in this area (Graves, 1980; Kirkpatrick, 1979; Manes, 1978).

At the conclusion of the class, Anderson (1986) used a combination of his observations of participant critical incidences across the course and summaries of participants' sex logs to draw numerous conclusions. It was first identified that at the start of the course participants self-identified as uncomfortable with sexuality-based discussions. This was noted as also being true for participants who reported previous experience with sexuality in relation to clients that they felt had already "desensitized" them to topics that were sexual in nature. Through Anderson's (1987) analysis of students' developmental process through the course he was able to identify 4 developmental stages that emerged across students' sex logs. The developmental stages

were noted as (a) self-examination of personal values and behavior; (b) an increased awareness of client concerns and reactions; (c) an increased freedom in discussing sexual material with other people who are not clients; and (d) an awareness of a new level of comfort in discussing sexual topics with clients. The study concluded that mental health clinicians will not by nature innately possess a comfort with sexuality-related client intervention and will need time to go through each of these 4 developmental stages, as it is theorized that a clinician cannot gain comfort with a later developmental stage without first mastering the stages that came before it (Anderson, 1986). A more recent study that is still historical in nature related to family therapists' comfort and willingness to discuss client sexual concerns was conducted by Harris and Hays (2008).

As limited previous research had investigated marriage and family therapists' (MFTs') comfort and willingness to address sexual topics with clients, this study sought to investigate how MFTs' training and education, perceived sexual knowledge, and comfort with sexual information influenced their willingness to engage in sexuality-related discussions with clients. A quantitative study of 175 clinical members of the American Association for Marriage and Family Therapy was conducted using self-report surveys. The self-report surveys were mailed out to participants and included measures of participants' demographics, sexuality education and supervision scale, clinical experience scale, perceived sexual knowledge scale, sexual comfort scale, and the sexuality discussions with client's scale. Results indicated that sexuality-specific education and supervision were helpful in starting a foundational level of participant sexual comfort, however those components alone were not enough to increase clinicians' willingness to

engage clients in sexuality-specific discussions. Sexuality-specific education and supervision increase a clinician's acquisition of sex knowledge and comfort in engaging in sexuality discussions in general, rather than with clients specifically. This supports Anderson's (1987) previous study of developmental stages of sexual comfort by demonstrating that sexuality-specific education and supervision support clinicians' moving through the first 3 developmental stages: (1) self-examination of personal values and behavior, (2) an increased awareness of client concerns and reactions, and (3) an increased freedom in discussing sexual material with other people who are not clients. However, results do not indicate that these components help MFTs reach the 4th developmental stage of Anderson's (1987) theorized developmental stages: an awareness of a new level of comfort in discussing sexual topics with clients. Results also indicated that once participants felt an increased comfort in discussing sexual topics in general (Stage 3 of Anderson's developmental stages) they were more likely to engage in sexuality discussion with their clients despite continued discomfort (Harris & Hays, 2008). Therefore, the authors theorize that the issue at hand may not be getting mental health providers to a place where they endorse comfort having sexuality-specific discussions with clients that do not produce provider anxiety, but rather to help support the development of mental health clinicians that can "sit with the anxiety and discomfort" that may inevitably arise from these types of client presentations and presenting problems treating clients who present for PSB work.

Study limitations were noted as a low participant response rate that had a disproportionate number of females in compared to males. The authors suggest that the

results be interpreted with caution as they may not be generalizable to other populations. However, despite the limitations of the study, Harris and Hays (2008) note the importance of the new academic knowledge this study provides as the first study analyzing MFTs' comfort and willingness to provide treatment to clients presenting with PSB. Harris and Hays noted that no known previous research has evaluated the role of supervision in supporting clinician comfort and willingness to work with clients presenting with PSB. The researchers also suggest the need for future research around obtaining a better understanding of what unique facets of sexuality-specific education and supervision make clinicians more willing to engage in sexuality-specific discussions with clients. As both previously discussed studies related to mental health clinicians' sexual comfort and named limitations around new invalidated measures of sexuality related to clinicians the next study provides an exploratory factor analysis of the sexual opinion survey (SOS) which may be a step towards filling that gap in the literature.

Bloom et al. (2015) headed the call for validating sexuality-related clinician measures to develop valid and reliable measures to be used in sexuality-specific education and training processes in the hope that these may aid in the evaluation of programs' effectiveness in increasing clinician comfort and willingness to engage in treating clients who present with PSB concerns. To accomplish this, the researchers conducted an exploratory factor analysis of the SOS with 813 licensed counselors and marriage and family therapists in the state of Florida. Results indicated that the SOS is a reliable and valid measure with moderately strong internal consistency that has a five-factor structure and serves as a measure of the negative and positive attitudes toward

sexuality held by mental health clinicians. Study limitations were identified by the researchers as a low participant response rate, limited previous research on the topic of clinician sexual comfort/sexual bias to base hypothesis on, and the out-of-date language of the SOS not being changed as the initial SOS was created in the 1980s. These potential limitations may have led to skewed results impacting the interpretability and generalizability of the current studies results. Bloom et al. concluded numerous academic, educational, and research applications for the SOS. Most relevant of these potential applications was the conclusion that the SOS could be used to further investigate how mental health clinicians' opinions of sexuality influence their willingness and effectiveness to identify and treat clients with PSB (Bloom et al., 2015).

Summary and Conclusion

Children account for more than 30% of the known instances of CSA nationwide (Jenkins et al., 2020). However very few research studies have investigated prevention and treatment for PSB in children ages 12 and younger. The studies that have been conducted have presented child- and family-reported barriers to attending and successfully completing treatment that would help the child reduce instances of acting out PSB in the future. These barriers included a lack of specialized PSB providers in the clients' region as well as the client and family not being successfully engaged in treatment because of the clinician's perceived judgmental stance towards the client and family. These two issues lead to clients with PSB either not having access to specialized PSB treatment or to treatment dropout. The present study aimed to investigate contributing factors that affect a lack of willing and effective mental health clinicians

who specialize in working with children who exhibit PSB.

SISE impacts a clinician's willingness to work with specialized populations of clients presenting with sexual concerns. If a mental health clinician is not comfortable, knowledgeable, and skilled with the subject matter of a client's presenting problem, they may be less confident and therefore less willing to work with a specialized population. The lack of effective and willing clinicians specialized to work with PSB in children may stem from clinicians' sense of being ill-equipped to work with this population of clients. Previous studies have indicated that when graduate programs increased clinician training for sexual-specific knowledge and intervention skills, their willingness to work with clients on sexual issues increased which led to an increased number of clients served who presented with sexual concerns. As clinicians work with more clients on sexual concerns, the clinicians' comfort level appears to increase, creating a cycle of more foundational knowledge to more willingness to more comfort and ultimately more clients served. DoS may also play a role here as clinicians with low DoS may mirror the client's emotional presentation, exhibiting discomfort, shame, fear, or other negative affect that is often present for clients presenting with PSB. This emotional reactivity towards the PSB by clinicians may not provide what is necessary to establish the effective therapeutic alliance necessary for children to feel comfortable and engaged to complete their needed PSB related treatment.

The identification of variables that can play a role in mental health clinicians being more willing and able to work with children who exhibit PSB could have a positive impact, with the potential to give clients early intervention and reducing CSA exhibited

towards other children. The findings of the study may lead to a better understanding of what factors impact mental health clinicians' willingness and ability to provide treatment to children who exhibit PSB. A better understanding of this may help better direct graduate programs, community mental health agencies, and child advocacy centers around what training, education, and support is needed to lay the foundation for mental health clinicians to engage in this treatment successfully. Chapter 3 provides an overview of the methodology used in the current study.

Chapter 3: Research Method

The purpose of this study was to examine the relationship between mental health clinicians' levels of DoS, SISE, sexual comfort, amount of sexual-specific education and training, and their willingness to provide treatment to children who exhibit PSB to have a better understanding of how these variables affect mental health clinicians' willingness to treat children who exhibit PSB. I conducted a quantitative research design to examine the effects of the predictor variables—DoS, SISE, and sexual comfort, amount of sexual-specific education and training—on the outcome variable: level of willingness to provide treatment to children who exhibit PSB. While previous research has examined and established each of the predictor variables having a relationship with professionals being willing and able to work with clients who present to treatment for sexual concerns (Hanzlik & Gaubatz, 2012; Harris & Hays, 2008; Heiden-Rootes et al., 2017; Miller & Byers, 2010), they have not examined the effect of each variable or their potential interaction on mental health clinicians' willingness to treat children who exhibit PSB. In this research study, I used multiple regression analysis and sought to find insight into the effects of DoS, SISE, sexual comfort, and sexual-specific education and training on mental health clinicians' willingness to provide treatment to children who exhibit PSB.

Chapter 3 includes an in-depth discussion of the quantitative design I used to examine the relationship between and the effects of the variables on one another. This section provides further detailed information on participants in the study, the minimum sample size, and the criteria for participation eligibility. I also provide a thorough overview of each of the self-report instruments used for data collection and interpretation

as well as presenting a discussion of the studies' data analysis, reliability and validity. This chapter concludes with a summary of the studies' research design and rationale, methodology, threats to validity and ethical procedures.

Research Design and Rationale

A quantitative non-experimental correlational design using a multiple linear regression analysis was chosen to determine the predictive relationships and interactions between the identified predictor variables and single outcome variable. The predictor variables that were used for the study are DoS, SISE, sexual comfort, and amount of sexual-specific education and training. The outcome variable that was used is willingness level of the mental health clinicians to work with children who exhibit PSB. A non-experimental correlational design best fit the research question, as the goal was to assess and compare preexisting qualities/demographics of mental health clinicians (DoS, SISE, sexual comfort and amount of sexual-specific training/education) in order to establish a foundational understanding of how these variables may be predictive of mental health clinicians' willingness to treat children who exhibit PSB. If the study identified significant predictive relationships between the variables, future research may choose to use these foundational findings to move forward with an experimental design when looking to create a training program to increase clinician willingness to work with this client population, though that was not the focus of the current study.

A non-experimental research design was also chosen in part due to its minimal time and resource constraints. As this type of research design can be implemented in self-report online surveys distributed to mental health clinicians nationwide it will likely take

less time to reach the needed participant numbers compared to other research methods. However, this design does have some time constraints as the completion of data collection was up to when the data collection reached its threshold for the number of responses coming in so that the minimum number of responses needed would be obtained. This type of design also called for resources such as permission to use previously developed measures of the variables, online survey distribution software such as Survey Monkey, and the statistical analysis program SPSS. Permission to use each of the self-report questionnaires named during this study was obtained from the previous researchers and can be seen in the appendices.

In general, research related to PSB in child populations and the mental health clinicians who serve them is in its infancy. In fact, most previous studies in this area have been qualitative or mixed methods in nature as those studies sought to establish a basis and foundational theory for future quantitative studies (Hanzlik & Gaubatz, 2012; Harris & Hays, 2008; Heiden-Rootes et al., 2017; Miller & Byers, 2010). There is also missing information that would prevent it being appropriate to jump to a full experimental design at this stage in the knowledge in this area causing that form of design to be premature in the development in this field. Therefore, a non-experimental quantitative design was an appropriate next stage in research development in this area as it is somewhat shallow and exploratory in nature but still allowed for new information to be obtained, laying the foundation for future experimental designs that could lead to the creation/identification of training programs for mental health clinicians being more willing and effective at working with children who exhibit PSB.

Methodology

Population

The target population for this study was actively practicing mental health clinicians who have graduated from their graduate training program at the master's level and are either working toward or have obtained licensure in their state of practice with at least 6 months of experience working with children ages 17 and younger. This study focused on master's level mental health clinicians as previous studies have identified an effect relationship between the study variables in doctoral level clinicians (Al-Darmaki, 2004; Hanzlik & Gaubatz, 2012), this study sought to build off of this connection and look at master's level clinicians, who are generally the clinician type providing ongoing weekly outpatient treatment to patients within community mental health. According to the U.S. Department of Labor there are currently an estimated 283,540 mental health clinicians nationwide, with roughly 82.6% of those clinicians practicing at the master's level (U.S. Department of Labor, 2022). This study did not look to include practitioners working at the bachelor's or doctoral level, as most states' licensure defines mental health clinicians as those practicing and providing treatment at the master's level or higher, and previous research has focused on the doctoral level. The participants carried a license or associate license in clinical social work (LICSW), marriage and family counseling (MFT), mental health counseling (LMHC)/professional counselor (LPC), substance use disorder professional (SUDP), or any of their variants from state to state to participate in this study.

Sampling and Procedure

This study implemented a non-probability or convenience sampling strategy (Fowler, 2014). A convenience sampling strategy means that in the data collection phase of this study, participants were chosen based on their availability to complete the survey and the meeting of specified inclusion criteria (Fowler, 2014). Although this sampling strategy is less desirable in comparison to methods such as random or strategic sampling, convenience sampling is the best fit for this study as it allowed for the incorporation of necessary inclusion and exclusion criterion, as well as allowing for efficient data collection through online survey distribution (Fowler, 2014). The survey was posted online using a survey platform such as Survey Monkey. Whoever replied to the survey first and met the inclusion criteria made up the participants of the study, demonstrating this as a convenience sample of participants. This form of sampling was decided on because this study had specific inclusion and exclusion criterion, as it was looking to evaluate a specific portion of the population. Therefore, convenience sampling is the only form of sampling that fit the purpose of study, ruling out random and strategic sampling as options due to the need for a specific type of participant, mental health clinicians who work with children aged 17 and under within the United States. Participant exclusion criteria were individuals who are actively providing mental health treatment to clients as part of their graduate education in a current internship, as this study sought to evaluate licensed mental health clinicians and associates at the master's level. Other exclusion criteria included individuals providing mental health services at the bachelor's or doctoral level, such as behavioral technicians or psychologists, as the focus of this study was

mental health clinicians at the master's level.

An a priori power analysis was performed to determine the minimum number of participants necessary in order to be able to conduct a multiple linear regression analysis with four predictor variables for the research study. The sampling size was statistically calculated using G*Power 3.1.9.4 (Faul et al., 2014). The alpha (α) level, effect size, power, and number of predictors was used to determine the sampling size for a multiple linear regression (Faul et al., 2014). The alpha level or p-value was set at .05, which is the norm in social sciences (Faul et al., 2014). The alpha level represents the probability that the null hypothesis will be rejected, which is a Type I error, also known as a false positive (McGrath, 2011). A Type II error is a false negative, which occurs when the null hypothesis is not rejected even though it is false (McGrath, 2011).

The power level represents the probability that the null hypothesis will be rejected. For this study, the power was set at .80 for an 80% probability. Setting the power level at 80% means there is an 80% chance of getting a statistically significant result when the effect is real. The higher the power level and sample size, the greater the chance of rejecting the null hypothesis (McGrath, 2011).

For this study, the effect size was .15 because a low to moderate effect size is usually the best indicator of the relationship between the variables (McGrath, 2011). The effect size, which is also known as the correlation coefficient, represents the correlation between the variables or the strength of the relationship between the variables (McGrath, 2011). A correlation coefficient of .10 represents a weak correlation, a correlation coefficient of .30 is a moderate correlation, and a correlation coefficient of .50 or larger

represents a strong or large correlation (McGrath, 2011).

G*Power 3.1.9.4 (Faul et al., 2014) was used to calculate a priori power analysis. I did so using an α level of .05, the power level at .80, and the effect level at .15. I then entered the four predictor variables. I determined that a minimum sample size of 85 would be required. The higher the power level, the higher the required sample size. For example, power levels of .80 and .95 would yield a required minimum sample size between 85 and 129 participants, which means that there is 80% or 95% chance of appropriately rejecting the null hypothesis.

Procedures for Recruitment, Data Collection, and Participation

All participant recruitment and data collection was done using the online platform SurveyMonkey, a survey software program that allows users to recruit participants, build complex multipart surveys, and collect and store data in one place (Survey Monkey, 2021). Participants were recruited through the SurveyMonkey Audience tool. This aspect of SurveyMonkey helps researchers recruit participants by opening access to the study to SurveyMonkey's pool of participants who meet the specific studies inclusion criteria. In order to assure that participants are quality sources of data collection, SurveyMonkey Audience uses the following strategies for participant recruitment and management: participants are all volunteers with no monetary reimbursement for each survey they complete; 50 cents is donated to a charity of the participant's choice; the participants are required to take regular self-profiling surveys to keep their demographic information up to date; and, lastly, participants are only sent a select number of survey opportunities that are best matched to their specific demographics to prevent them from being flooded with

frequent participation in studies. SurveyMonkey Audience's participation pool is over 50 million individuals worldwide and allows for screening of potential participants by demographics, geography, and profession, which met the participant screening needs of this study (SurveyMonkey, 2021).

After I entered my participant inclusion and exclusion criteria, SurveyMonkey made the study live in their database and sent recruitment material to participants in their pool of individuals who matched the needed study criteria. When this occurred, each potential participant received an email from SurveyMonkey informing them that they had been assigned to the study. This email also prompted them to proceed to the study for participation instructions using a unique participant link embedded in the email. Once participants followed their unique study link, they were directed to a page that displayed the study informed consent document. This document included the purpose of the study, participants' rights to withdraw from participation at any time without negative consequence, and their right to not answer any items they wish not to complete. The informed consent page also included researcher and university contact information including IRB study approval information and a statement of risk related to the content of survey items, as the subject matter relates to sensitive subject matter around children, youth, trauma, and human sexuality. It also included contact information for two national hotline resources for support should the participant have any adverse response to the survey questions. These resources can act as crisis support and help participants connect to mental health resources in their area. When each potential participant has fully reviewed the informed consent, they had the option to either begin participation in the

study at that time or withdraw from the study at that time, by clicking a “Continue” or “Withdraw” button at the bottom of the page. If participants chose to proceed with study participation, they were then directed to complete further detailed screening information and detailed demographic data before being prompted to complete each of the specific study questionnaires, which are discussed in more depth later in this chapter.

As each participant agreed to the terms described within the informed consent, they were given an opportunity to answer a set of additional in-depth screening questions that included the study inclusion criteria of being an active practicing masters level mental health counselor living within the United States with at least 6 months of experience working with children ages 17 and younger, in addition to questions around the study’s exclusion criterion to rule out any mental health providers working with clients at the bachelor’s level, pre-master level (interns who have not yet graduated from their master’s program) or doctoral level practitioners as this study aimed to look at mental health clinicians who have graduated from a master’s level program and are actively practicing clinical work with clients. If the participant met those criteria they were allowed to proceed with participation in the study. However, if they did not meet inclusion criteria, or endorsed a study exclusion criterion, they were automatically redirected the study debrief page and then to a new study opportunity in real time.

Although general geographic and professional status information was collected in the participant screening process once participants met study inclusion and exclusion criterion have been identified, further demographic information was collected to support the interpretation of data collected during the study. This demographic information

included the following information: age, sex, gender, ethnicity, degree types earned (i.e. BA/BS, MS/MA), educational program name (clinical psychology, counseling psychology, social work etc.), years degrees were obtained, whether the participant received sexuality-specific training in their graduate program (i.e., how many courses participants have attended that included sexuality-specific training), was the participant fully independently licensed or do they hold an associates license, what type of license do they hold (LMHC, LPC, LMFT, LICSW, etc.), whether the participant participated in/received sexuality-specific training since completing their graduate program, how many years they have been actively practicing, and whether they practiced in private practice, community mental health, or both settings. When the demographic information page was completed, the participant was able to click on the “Next” button to move them forward to each subsequent study questionnaire, which were on their own pages. At the bottom of the screen for the final questionnaire the participant was met with a “Complete Study” button which directed them to the final screen of the study.

The final step of participation occurred once the participant successfully completed all questionnaires. At that time, they were redirected to a debriefing statement. The debrief page included the contact information for this study, including this researcher and IRB, purpose of the study, and a message of gratitude thanking them for their participation in the study to help further support the field of psychology. Participants were also encouraged to reach out to me if they would like to follow up with result of the data analysis or for support with any negative impacts from study participation. No follow up procedures were needed as part of the design of this study.

Instrumentation and Operationalization of Constructs

This study used the Differentiation of Self Inventory-Revised (DSI-R), Sexual Intervention Self-Efficacy Scale (SISES), Sexual Comfort Scale (SCS), Willingness to Treat Sexual Issues Scale (adapted) (WTSI-A) and a self-created demographic questionnaire for data collection. The DSI-R measured the level of DoS (low to high) including four subscales of DoS; the SISES measured the overall level of SISE as well as three subscales of SISE; the SCS measured the participants level of comfort with sexual topics; and the WTSI-A measured participants' willingness to treat sexual issues. The original WTSI was adapted to specifically target participants' willingness to treat children aged 12 and younger who present to treatment with PSB, as the original measure currently is structured to assess participants' willingness to treat adults for sexual concerns rather than the target population (children age 12 and younger). The demographic questionnaire included participant age, sex, gender, sexual orientation, current state of residency, religious orientation, ethnic background, type of educational programs attended, degrees earned, license type, licensure status (fully licensed versus associate license), personal history of sexual trauma and PSB for self or family, years of clinical experience, working in private practice or community mental health, currently seeing clients, caseload size, specialty area, history of treating clients for PSB, and history of treating children age 12 and younger with PSB.

DSI-R

The DSI (initial version of the DSI-R) was developed to further examine the construct of DoS as few studies had empirically examined Bowen's theory (M. Bowen,

1976,1978; M. E. Kerr & Bowen, 1988), hypotheses, and constructs. The development and evaluation of the DSI by Skowron and Friedlander (1998) was meant to fill this gap in the literature. The DSI was created to measure adults' ability to differentiate the self within their significant relationships using four subscales of DoS: emotional cutoff, emotional reactivity, fusion with others, and the ability to speak from the "I" position (Skowron and Friedlander 1998). An initial form of the DSI that consisted of 96 items was administered to adult participants living in New York, Ohio, and California. The participants included (a) randomly selected faculty and staff at a large state university; (b) parents of children on a suburban athletic team; (c) graduate students in counseling psychology, clinical psychology, and social work; and (d) available friends and acquaintances of research team members (N=313) across three studies. Four factors emerged leading to a reduction of items from 96 items to 43 items (Skowron and Friedlander,1998).

The DSI was found to have internal consistency reliabilities that were moderate to high (DSI $\alpha = .88$; Emotional Reactivity $\alpha = .88$; I Position $\alpha = .85$; Emotional Cutoff $\alpha = .79$; Fusion with Others $\alpha = .70$) when assessing the overall construct of DoS and its three initial subscales. These internal consistency scores were similar across the three initial studies indicating a basis for test/retest reliability. Skowron and Friedlander (2003) then built off their initial 1998 studies that had been theoretically and psychometrically sound for the overall DoS construct and three of its subscales to revise the Fusion with Others (FO) subscale to improve the subscale reliability and validity. Their analysis resulted in a revised 12-item FO subscale with increased internal consistency reliability and construct

validity. This resulted in the DSI-R which exhibited high internal consistency reliability for the overall construct of DoS as well as all four subscales including the new 12-item FO subscale ((DSI-R $\alpha = .92$, Emotional Reactivity $\alpha = .89$; 1 Position $\alpha = .81$; Emotional Cutoff $\alpha = .84$; Fusion with Others $\alpha = .86$). This psychometric analysis supports the DSI-R as a reliable measure of DoS.

Convergent validity was assessed in several ways. First, the full DoS scale was moderately to highly correlated to each of the subscales, while the individual subscales showed low correlations (Skowron and Friedlander, 2003). This primarily indicates that each subscale is a unique subscale of DoS that has a direct highly significant relationship with DoS as a construct. Second, the DoS and its four subscales showed correlational relationships with two Fusion/Individuation scales, two attachment scales, trait anxiety, marital adjustment, and self-report differentiation (Skowron and Friedlander, 1998 & Skowron and Friedlander, 2003). All of which were theorized by Bowen to be related components of DoS. The instrument has strong internal consistency, test-retest reliability, and convergent validity (M. Bowen, 1976, 1978; M. E. Kerr & Bowen, 1988). The purpose of the study was to explore the effect of mental health clinicians' level of DoS on their willingness to treat children with PSB and the DSI-R is the most widely used measure of DoS for researchers and clinicians (Sloan and Dierendonck, 2016) so it was appropriate for use in this study. To calculate the DSI-R subscales, items from that subscale are summed together and divided by the total number of items in the subscale with some items being reverse-scored prior to their summation. The scores range from 1 to 6, with higher scores indicating higher levels of DoS. This same process was followed

to obtain an overall level of DoS across subscales. The Letter of Permission to use this questionnaire from the researchers can be found in Appendix E.

SISES

The SISES was developed by Miller & Byers in 2008 based on previous measures of self-efficacy and literature on sex therapy and self-efficacy (Al-Darmaki, 2004; Bandura, 1997; Forester et al., 2004; Harvey & Mc-Murray, 1994; Holden et al., 2002) in order to be able to explore the self-efficacy of clinical psychology graduate students related to providing sexuality-based interventions, as previous scales for sexuality-based intervention self-efficacy had not been developed in the academic literature (Miller & Byers, 2008). The SISES consists of 19 items on a 6-point Likert scale ranging from “1-Strongly Disagree” to “6-Strongly Agree,” with higher scores indicating higher levels of self-efficacy. Analysis of the SISES revealed three specific factors of SISE: the sex therapy skills subscale (Skills Self-Efficacy), relaying sexual information subscale (Information Self-Efficacy), and sexual comfort/bias subscale (Comfort Self-Efficacy).

Both the full scale and the subscales were found to have moderate-to-high internal consistency: Sex Therapy Skills $\alpha = .87$; Relaying Sexual Information $\alpha = .88$; Sexual Comfort/Bias $\alpha = .73$; and Total Sexual Intervention Self Efficacy Scale $\alpha = .88$. However, the SISES is deemed as an exploratory scale by Miller & Byers (2008) due to no further reliability or validity data being collected, as no known academic literature has used or further evaluated the SISES at this point in time. As this is the only current known scale developed to assess clinicians' level of SISE, this scale was appropriate for use in the present study, despite its lack of data related to its reliability and validity. All items from

the SISES and its four subscales are rated on a 6-point Likert scale ranging from Strongly Disagree (1) to Strongly Agree (6). Each item within the subscales were summed to obtain the subscales' scores, with higher scores indicating higher levels of SISE for that subscale's type of self-efficacy. All four subscales were then summed to obtain the overall SISE score, with higher scores indicating higher levels of overall SISE. The Letter of Permission to use this questionnaire from the researchers can be found in Appendix C.

SCS

Harris & Hays (2008) developed the SCS, consisting of 17 items on a 7-point Likert scale (1 = Very Uncomfortable to 7 = Very Comfortable), to assess clinicians' level of comfort discussing sexual issues with a wide variety of client types (children, teens, adults, minorities, etc.) and other professionals (supervisors and colleagues). Harris & Hays developed the SCS based on Graham & Smith's 1984 qualitative study involving in-depth interviews of 32 sex educators and sought to operationalize the construct of "sexual comfort," as no previous studies had created a measure of sexual comfort (Harris & Hays, 2008). The SCS was developed in the context of their study investigating family therapists' comfort and willingness to have sexual discussions in treatment, which had a sample size of 175 participants (Harris & Hays, 2008). As this study included the initial development of the SCS, limited information on the measure's validity and reliability is available. However, the SCS's internal consistency was found to be high ($\alpha=.86$) and the items appear to align with the identified components of the "sexual comfort" construct in the original Graham & Smith (1984) study (Harris & Hays, 2008). Overall, the SCS was

an appropriate tool for this study as it assessed mental health clinicians' comfort discussing sexual issues in treatment; is inclusive of the child aged population this study sought to investigate; and is the only current measure in the academic literature that bases a sexual comfort measure on the previous qualitative research that established the operational definition of "sexual comfort". To obtain an overall SCS score, all 15 items were summed, with higher scores indicating higher levels of sexual comfort for participants. The Letter of Permission to use this questionnaire from the researchers can be found in Appendix D.

WTSI-A

The WTSI was developed by Miller & Byers in 2008 as part of their study discussed above on SISE, which had a sample of 172 clinical psychology graduate students enrolled in programs in both the United States and Canada. The scale was developed as part of this study because no previous studies had developed a scale that looked at therapists' willingness to treat clients presenting to treatment with sexual concerns. Four items on a 6-point Likert scale, from Strongly Disagree (1) to Strongly Agree (6), make up the WTSI, with higher total scores on the scale indicating higher levels of clinician willingness to treat sexual concerns. A factor analysis was performed, and the original 9 items were distilled down to these final 4 items that showed 1 factor (the construct of clinician willingness to treat sexual concerns). Internal consistency of the scale was found to be high with an $\alpha = .83$. However, as the WTSI stands, it is not fully representative of what this study sought to measure.

The original WTSI looks at clinician willingness to treat sexual issues with an

emphasis on treating adult sexual issues. As the present study assessed clinicians' willingness to treat child PSB, the four items will be revised to better suit the population of this study. The WTSI's four items are as follows: 1) If a couple told me that they were having a sexual problem, I would refer them to another clinician; 2) I think that it would be best to refer a client if they had a sexual concern/problem; 3) I would probably do more harm than good if I tried to work with an individual who had a sexual concern/problem; and 4) I would refer a client who is having concerns about their sexual orientation to another therapist. The WTSI-R created specifically for the present study adapted the four items as follows: 1) If a child (age 12 and under) or their caregiver told me that they (the child client) were having a sexual problem/issue/concern I would refer them to another clinician; 2) I think that it would be best to refer a child (age 12 and under) client if they had PSB; 3) I would probably do more harm than good if I tried to work with a child (age 12 and under) who had PSB; and 4) I would refer a child (age 12 and under) client who is having concerns about their sexual orientation to another therapist. Revising the four items to better reflect mental health clinicians' willingness to treat children presenting to treatment with PSB allows the already established WTSI to be used and further validated through its implementation in the present study. The questions are on a 6-point Likert scale ranging from Strongly Agree (1) to Strongly Disagree (6). The four items will be scored by adding the four responses together. Higher scores indicate a higher rate of willingness to treat children ages 12 and younger who present to treatment with PSB. The Letter of Permission to use this questionnaire from the researchers can be found in Appendix C.

Operationalization of Variables

I will now provide operational definitions for this study's demographics, predictor and outcome variables.

DSI-R. This study used Bowen's (1978) definition to operationally define the construct of DoS as all studies related to the construct of DoS utilize Bowen's definition. Bowen defined DoS as "the degree to which an individual can balance emotional with intellectual functioning and closeness with independence in relationships with others" (Bowen, 1978). The current study used the DSI-R, which is a 43-item scale measuring DoS as both an overall construct and its four identified subscales of Emotional Reactivity, "I" Position, Emotional Cutoff, and Fusion with Others. All items are self-report on a 6-point Likert-type scale where 1 represents "not at all true of me" and 6 represents "very true of me" (Heiden-Rootes, Brimhall, Jankowski & Reddick, 2017). The following are examples of items from each of the four subscales: emotional cutoff (e.g., "I have difficulty expressing my feelings to people I care for"), emotional reactivity (e.g., "People have remarked that I'm overly emotional"), fusion with others (e.g., "I usually need a lot of encouragement from others when starting a big job or task"), and the ability to speak from the I-position (e.g., "I tend to remain pretty calm even under stress"). Scoring will include reverse coding on several items, and higher scores indicate a greater ability to self-regulate intra- and interpersonal dimensions. The DSI-R has been shown to have high internal consistency reliability for the overall construct of DoS as well as all four subscales (DSI-R $\alpha = .92$, Emotional Reactivity $\alpha = .89$; I Position $\alpha = .81$; Emotional Cutoff $\alpha = .84$; Fusion with Others $\alpha = .86$) (Heiden-Rootes, Brimhall,

Jankowski & Reddick, 2017).

SISES. The definition of SISE is based upon Bandura's (1982 and 1997) definition of self-efficacy and Miller & Byers' (2008) definition of what encompasses the components of a therapeutic sexual intervention. SISE was operationally defined as "the extent of the belief that a mental health clinician has that they are capable of performing the specific tasks of: Sex Therapy Skills, Relaying Sexual Information, Exhibiting Comfort with Sexual Topics, and Exhibiting Personal Bias with Sexuality-based Topics". The SISES consists of 19 items on a 6-point Likert scale ranging from 1-Strongly Disagree to 6-Strongly Agree, with higher scores indicating higher levels of self-efficacy. Items 1, 2, 3, 8, 9, and 11 are reverse coded. The Comfort/Bias Self-Efficacy subscale is made up of items 2, 4, 7, 9, and 11. The Skill Self-Efficacy subscale is made up of items 1, 3, 5, 6, 8, 10, and 12. The Information Self-Efficacy subscale is made up of items 13a to 13g. An example item is as follows: "I worry that I would seem uncomfortable if a client talked to me about masturbation". Both the full scale and the subscales were found to have moderate to high internal consistency: Sex Therapy Skills $\alpha = .87$; Relaying Sexual Information $\alpha = .88$; Sexual Comfort/Bias $\alpha = .73$; Total Sexual Intervention Self Efficacy Scale $\alpha = .88$ (Miler & Byers, 2008).

SCS. Graham and Smith's (1984) qualitative study operationally defined the complex construct of sexual comfort as a "cognitive, affective, and behavioral response to sexuality". In addition to this, Graham and Smith (1984) also identified that sexual comfort is "a developmental task that is influenced by physiological, psychological, sociological, religious and spiritual, educational, and sexual parts of the self". Harris &

Hays (2008) developed the SCS based upon the Graham and Smith (1984) operational definition, consisting of 17 items on a 7-point Likert scale (1= Very Uncomfortable to 7= Very Comfortable). Higher scores indicate a higher level of sexual comfort. An example item from the scale follows: “Please indicate how comfortable you are or would be discussing sexuality issues in the following modalities: Individual, Group, Couples, Family, and Supervision” (Harris & Hays, 2008). Cronbach’s alpha for the Harris & Hays (2008) study was $\alpha = .86$.

Sexuality-Specific Education and Training. This predictor variable was assessed through two questions that were included as part of the demographic questionnaire (Appendix B). The two questions inquired about how many sexuality-specific education courses and postgraduate trainings the participant has attended.

Sexuality-specific training in graduate school: How many courses containing sexuality-specific education did the participant take during their time in college.

Post-graduation sexuality-specific training: How many trainings that included sexuality-specific training material has the participant attended at the time of the study following the completion of their graduate degree.

Demographic Questions

A demographic questionnaire (see Appendix B) will be included in the survey that was distributed to the nationwide pool of mental health clinicians on SurveyMonkey. The self-administered assessment included age, sex, gender, race, location of practice, education location, highest degree earned, educational program name, year of graduation from highest level of education, sexuality-specific training in graduate school, licensure

status, licensure type, post-graduation sexuality-specific training, graduate program, years of active practicing, caseload size, PSB treatment experience, sexual trauma history, and practice setting.

The operational definitions for the independent variables are, as follows:

Age: The length of time (in years) the participant has been alive.

Sex: Either of the two main categories (male or female) that humans are divided into based on their reproductive organs at birth.

Gender Identity: The way in which the participant identifies their gender at the time of their participation in the study (male, female, or other)

Race: Categories of human beings that share distinctive physical characteristics (White, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander, Hispanic, or Other).

State of practice: The state in which the mental health clinician has provided the majority (50% or more) of their clinical practice.

Education Location: The state in which the participant attended their highest level of education.

Highest degree earned: The mental health clinician's highest degree earned at the time of the study (AA, AS, BA, BS, MA, MS, Ph.D., Psy.D)

Educational program name: The name of the participant's highest level educational program (Psychology, Counseling, Clinical Psychology, Social Work, Marriage and Family Counseling).

Graduate program school: Name of the school where the participant attained their

highest level of education.

Year of graduation from highest level of education: The year that the participant graduated from their highest level of education.

Licensure status: Whether the participant is fully licensed or an associate license at the time of their participation in the study.

Licensure type: The type of license the participant currently holds (LMFT, LPC, LMHC, LICSW).

Years of experience: The length of time (in years and months) that the mental health clinician has provided mental health counseling (including postgraduate and internships where mental health counseling services were provided).

Practice setting: The type of work setting that the participant is currently working in (private practice, outpatient community mental health, inpatient psychiatric hospital, general hospital, school/university, intensive outpatient, and other community agency such as hospice or child protective services)

Caseload size: The number of clients assigned to the mental health clinician at the time of taking part in the study.

PSB treatment experience: Whether the mental health clinician has provided treatment to anyone aged 13 or over who present to services with PSB.

Child PSB treatment experience: Whether the mental health clinician has provided treatment to children ages 12 and younger who present to services with PSB.

Sexual trauma history: Does the mental health clinician, their family members, or their friends have a history of experiencing or witnessing any form of sexual abuse

including but not limited to sexual harassment, molestation, incest, or rape.

Outcome Variable. The outcome variable was mental health clinicians' willingness to treat children ages 12 and under who present to treatment for PSB. Harris and Hayes (2008) defined willingness to treat sexual issues as "a mental health clinician accepting new clients who identify as seeking services to specifically address sexual issues (sexual problems, sexual orientation, sexual dysfunction, or sexual relationship dynamics), as well as a mental health clinician's willful engagement in the discussion of sexual issues during the course of treatment". The Willingness to Treat Sexual Issues Scale Revised (WTSI-R) is a 4-item scale assessing mental health clinicians' level of willingness to treat children ages 12 seeking counseling for PSB (Miller & Byers, 2008). The following is an example item from the scale: "I think that it would be best to refer a client if they had a sexual concern/problem". Participants' responses will be provided on a 6-point Likert scale ranging from Strongly Disagree (1) to Strongly Agree (6). Higher scores represent a greater willingness to treat clients ages 12 and younger with sexual issues (Miller & Byers, 2008).

Data Analysis Plan

The method of data collection was through online self-report surveys, a method which was chosen for this study due to its numerous advantages that I further discussed in this chapter. This online survey method allowed the study to be distributed using SurveyMonkey, which made for easy access to the study for participants nationwide. This allowed for the potential to increase the response rate for participation, allowing for higher numbers of participants, which would have increased the power of the results'

interpretability and generalizability. Increased participant pool scale was an important factor for this study in particular as previous research has mostly focused on small sample sizes in one geographically isolated area of a nation, with many of the previous studies being conducted outside of the United States in areas such as the United Kingdom and Australia (Hanzlik & Gaubatz, 2012; Harris & Hays, 2008; Heiden-Rootes et al., 2017; Miller & Byers, 2010). Additionally, this method of data collection theoretically allowed for a large amount of data to be collected in a short period of time, making for a more efficient and feasible study if effective.

The data collected was statistically analyzed using the Statistical Program for Social Sciences (SPSS) program, version 30. Prior to any data analysis, all collected data was cleaned and screened to remove any incomplete data provided by participants during the data collection process and to assure an accurate data file had been obtained from the data collection company SurveyMonkey. The data screening and cleaning occurred in two steps: 1) the data file provided by SurveyMonkey was proofread to assure its accuracy; 2) the data was then checked for any missing data and it was also assessed if the missing data appears random or reveals a participant pattern. If no pattern existed, the missing data will be replaced. If a pattern in missing data emerged, I followed the guidelines for missing variables (Tabachnick & Fidell, 1996), and if participants did not complete all surveys, the data was not included in the study. The dataset was then analyzed to assure it met the assumption requirements for the planned Multiple Linear Regression analysis. Four assumptions must be met in order for the use of a Multiple Linear Regression analysis: 1) A linear relationship between the independent and

dependent variables; 2) Multivariate normality, where the residuals must be normally distributed; 3) No Multicollinearity, i.e. the independent variables cannot be highly correlated with each other; and 4) Homoscedasticity, where the variance of error must be similar across all the predictor variables. The linear relationship between the predictor and outcome variables was assessed using a scatterplot. Normality was assessed through the Kolmogorov-Smirnov “Goodness of Fit” test, which was performed on the residuals of the regression. The multicollinearity assumption was checked through a correlation matrix of all the predictor variables where the correlations should be no greater than $p < 0.80$. Lastly, homoscedasticity was assessed through an additional scatterplot of the residuals versus the predicted values, which should display no clear pattern. The Multiple Linear Regression also requires at least two predictor variables that are ordinal, nominal, or interval/ratio: the present study had four such variables of this type.

The following research question and hypothesis were used to examine the combined and unique relationships between DoS, SISE, Sexual Comfort and sexuality-specific and training on mental health clinicians’ level of willingness to treat children ages 12 and younger who present to treatment to address concerns related to PSB.

RQ 1: What is the extent of the combined and unique relationships between mental health clinicians’ DoS, SISE, sexual comfort, and amount of sexuality-specific education and training, and mental health clinicians’ willingness to provide treatment to children who exhibit PSB?

H_{01} : There are not significant combined and unique relationships between DoS, SISE, Sexual Comfort, and sexuality specific education and training that affect mental

health clinicians' willingness to treat children ages 12 and younger who present to treatment for PSB.

H₁₁: There are significant combined and unique relationships between DoS, SISE, Sexual Comfort, and sexuality specific education and training that affect mental health clinicians' willingness to treat children ages 12 and younger who present to treatment for PSB.

To analyze RQ 1 a multiple linear regression (MLR) was conducted to assess the extent of the combined and unique relationships of DoS, SISE, sexual comfort, and sexuality-specific education and training effect on mental health clinicians' willingness to treat children ages 12 and younger who seek treatment for PSB.

This foundational analysis is necessary, as previous studies have shown independent relationships between the predictor and outcome variables when the clients presenting to sexuality-focused treatment were adolescents and adults, not children ages 12 and younger (Hanzlik & Gaubatz, 2012; Harris & Hays, 2008; Heiden-Rootes et al., 2017; Miller & Byers, 2010). Previous studies also established this variable relationship when looking at nurses, psychologists, and Marriage and Family Therapists (MFT) (Hanzlik & Gaubatz, 2012; Harris & Hays, 2008; Heiden-Rootes et al., 2017; Miller & Byers, 2010) but have not assessed this as a factor for mental health clinicians who are more likely to have frequent interactions with these types of clients. There has also not been an analysis of the predictor variables' combined effects on the outcome variable to be able to better understand their interactions, which allow the identification of which predictor variables have the largest effect on the outcome variable. Obtaining this

information will help researchers and practitioners alike better understand how to best support mental health clinicians in the development of willingness to treat this population.

Threats to Validity

Two major types of validity exist which can impact a research study result and can minimize the researcher's ability to draw accurate conclusions from the results of the study: internal and external validity (Creswell, 2009).

Internal Validity

Internal validity is the degree to which a researcher can confidently state that the results of their study are due solely to the interactions between the predictor and outcome variables. It is also known to be the extent to which the study instruments accurately assess each given variable they are meant to measure. Some of the most significant threats to internal validity can come from attrition and instrumentation issues (Campbell & Stanley, 1963; Creswell, 2009). This study will mitigate internal validity threats from instrumentation as instruments chosen for this design fit the sample population, mental health clinicians in the United States, and have shown to be accurate measurements of this study's identified predictor and outcome variables, DoS, SISE, sexual comfort, sexuality-specific education and training, and clinician willingness to treat children 12 and younger who present to treatment with PSB. Each instrument chosen for this study was developed with an adult population of mental health clinicians as the target population and each instrument has demonstrated moderate to high levels of internal consistency, making them reliable measures of this study's variables.

It also must be noted that the study's sample population included selection inclusion criteria: all participants were mental health clinicians actively practicing within the United States. Although this inclusion criteria was necessary for the purposes of this study, it has some effect on the internal validity of the study that cannot be mitigated. An additional threat to internal validity that cannot be controlled is attrition or the loss of participants during the survey prior to its completion. Since it is ethically required that participants be able to withdraw their participation at any point during the study, attrition is likely to occur. However, predicting attrition rates cannot be done, as attrition can vary from study to study (Campbell & Stanley, 1963; Creswell, 2009). This threat to validity had intention to mitigate this by collecting a robust sample size of participants significantly larger than the required number of subjects to be sure to secure enough data despite any attrition that occurred. The non-experimental design of the study helped to counter any threats from researcher or response bias, as participants completed the survey online and did not have access to this researcher, other participants, or their responses on the survey.

External Validity

External validity refers to the likelihood that causal relationships identified in a study's result can be maintained across variation in sample, setting, treatment, or outcome. The most common threat to external validity is the generalizability of the results to a larger population outside of the study sample of participants. Generalizability can be problematic due to an interaction between the study's setting, timing, or participants (Creswell, 2009). As this study analyzed a specific population of mental

health clinicians actively practicing in the United States, this should be noted as a study limitation with results not being generalized outside of the study population. Therefore, this study's findings should only be applied to the study's participant population, which mitigates the effect on external validity in the present study. Also, these limitations should be explicitly stated and implications on future research be discussed within the results of this study.

Ethical Procedures

Conducting research with human participants required the submission and approval of an application to the Walden University Institutional Review Board (IRB) prior to beginning the data collection process. The application clearly presented how the proposed study met the IRB's regulatory standards for the protection of human research. Once the Walden University IRB reviewed and approved the application, an approval number was issued (approval # 08-08-23-1005886). After being approved the survey was posted and made live on the SurveyMonkey platform and data collection began. At the time of the study, SurveyMonkey sent out a notification to all active members on their platform who have identified themselves as mental health clinicians (Appendix A: Letter to Participants). The notification from SurveyMonkey to perspective participants included the risks and benefits of completing the survey. Once participants choose to begin the survey, they were directed to a secure survey link that first displayed a message that participation is voluntary and that participants have the right to stop the survey at any point for any reason, without any negative impacts (SurveyMonkey, 2021). Participants then viewed and agreed to the informed consent for this study which included the

following:

1. Brief description of the study
2. Inclusion criteria
3. How contact information was obtained
4. Informed consent process
5. Background information about the study
6. Procedures
7. Sample questions for questionnaire
8. Voluntary nature of the study
9. Risks and benefits of being in the study
10. Confidentiality of information
11. Contacts and questions
12. Obtaining participant consent

Participants were informed that their participation in the study guarantees them full confidentiality and anonymity, as the researcher had no personally identifying information about the participants. During the survey, participants were not asked to disclose any personal identity information, and this researcher had no knowledge of which participants fully completed the survey. There was complete adherence to the IRB guidelines that students of Walden University conducting research must do so in an honest and accurate way. Through convenience sampling using the SurveyMonkey platform, participants were able to complete the survey including the DSI-R, SISES, SCS, WTSI-A, and a demographic questionnaire that inquired around the participant's

age, sex, gender, race, location of practice, education location, highest degree earned, educational program name, year of graduation from highest level of education, sexuality-specific training in graduate school, licensure status, licensure type, post-graduation sexuality-specific training, graduate program, years of active practicing, caseload size, PSB treatment experience, sexual trauma history, and practice setting.

When data collection was complete the data was exported to SPSS and stored on a password-protected computer that can only be accessed by this researcher. All data from this research study was stored and handled in accordance with Walden University's recommended guidelines. It is a requirement of Walden University that all raw research data be kept and stored securely for a minimum of five years following the completion of the research study. To meet the data storage requirement at this time the data is stored in two places: a password-protected computer and an external hard drive that is also password-protected.

Two potential ethical dilemmas were identified during the proposal process: 1) the minimal compensation given to participants by SurveyMonkey, as when compensation is given for research participation it needs to be assured it is not a coercive amount and 2) some questions across the questionnaire inquire about sensitive topics of sexual issues, including one question that asks participants if either they or close family or friends have experienced sexual trauma. To address the first ethical concern, the participant compensation given by SurveyMonkey is viewed by SurveyMonkey as non-coercive, due to it being under a dollar amount for a study that on average took participants over thirty minutes to complete and did not go directly to the participant but

was donated to a charity of their choosing. The second ethical concern was mitigated through informed consent procedures that clearly gave examples of the sensitive sexuality questions that were covered during the course of the questionnaire and listed several national hotlines for participants to access mental health services or crisis support if adverse reactions occurred due to their participation in the study. Both phone lines were through Substance Abuse and Mental Health Services Administration (SAMHSA). The first was a support line to help individuals identify treatment resources in their local area (1-800-662-HELP (4357)). The second line was for crisis services for more acute participant responses (1-800-273-TALK (8255)). As a Walden University student, I assured a commitment to ethical research by adhering to all procedures and guidelines set forth by the university.

Summary

In this study, a quantitative non-experimental survey research design was used to examine the relationship between DoS, SISE, sexual comfort, and sexuality-specific education and training on mental health clinicians' willingness to treat children ages 12 and younger who present to treatment for PSB. The participants in the study were mental health clinicians from across the United States who have graduated from their graduate training programs and either held a state license or associate state license to actively practice mental health counseling. The instruments in this study will be the DSI-R, SISES, SCS, WTSI-A, and a demographic questionnaire that inquired around the participant's age, sex, gender, race, location of practice, education location, highest degree earned, educational program name, year of graduation from highest level of

education, sexuality-specific training in graduate school, licensure status, licensure type, post-graduation sexuality-specific training, graduate program, years of active practicing, caseload size, PSB treatment experience, sexual trauma history, and practice setting. The data that is collected was statistically analyzed using the SPSS version 30 software. Prior to data analysis, the data was cleaned and screened using a two-step process to assess for incomplete and unusable data. The data was then be analyzed and descriptive statistics will be obtained for the DSI-R, SISES, SCS, WTSI-A, and all the instruments' subscales. A series of regression and multiple linear regression analyses were used to determine if DoS, SISE, sexual comfort, and sexuality-specific education and training have an effect or combined effect on mental health clinicians' willingness to treat children ages 12 and younger who seek treatment for PSB. Chapter 4 provides an overview of the purpose of this study, restates the research questions and hypothesis, provide the results of the surveys, and provides a summary of the data analysis.

Chapter 4: Results

The purpose of the present study was to gain insight into four predictor variables—DoS, SISE, sexual comfort, and sexuality specific education and training—and how they affect the outcome variable: mental health clinicians' level of willingness to treat children who present for treatment with PSB. The study used a quantitative survey design and data analysis was completed to assess the extent of the relationship of the predictor variables on the outcome variable using the below research questions and hypotheses:

RQ 1: What is the extent of the combined and unique relationships between mental health clinicians' DoS, SISE, sexual comfort, and amount of sexuality-specific education and training, and mental health clinicians' willingness to provide treatment to children who exhibit PSB?

H₀1: There are not significant combined and unique relationships between DoS, SISE, Sexual Comfort, and sexuality specific education and training that affect mental health clinicians' willingness to treat children ages 12 and younger who present to treatment for PSB.

H₁1: There are significant combined and unique relationships between DoS, SISE, sexual comfort, and sexuality specific education and training that affect mental health clinicians' willingness to treat children ages 12 and younger who present to treatment for PSB.

Chapter 4 provides an introduction and overview of the study, its research questions and hypothesis. Data collection is discussed in detail and includes collection

timeframes, participant response rates and alterations that were required to complete the current study. This chapter will also provide a complete overview of all required deviations from the original data analysis plan and its impact on the study validity. Descriptive statistics are presented related to the final study sample. A thorough review of the statistical assumptions is presented in the chapter including all associated tables and figures. Lastly, the results of the statistical analysis conducted to address the research question are presented and summarized followed by a transition into the discussion and conclusions of the results in Chapter 5.

Data Collection

Time Frame and Recruitment

All data were collected using the detailed data collection plan in Chapter 3. Any alterations to the collection approach are noted in the following sections. Data collection occurred between October 2023 and March 2025. The survey was available through Survey Monkey , and the survey link was made available to all Survey Monkey users. Once the survey was made live on the platform, the link to the survey was posted in the Walden University participation pool, LinkedIn, and several Facebook groups including The Psychotherapy Network, University of Washington Harborview Medical Center, and Seattle Children’s Hospital. As the data collection process was longer than anticipated, lasting a total of 19 months, numerous efforts were made to further recruitment, and the survey was reposted on these platforms numerous times across this time period. Original IRB approval for the study was given for August 8, 2023, to August 7, 2024. Due to the extended length of data collection, a data collection extension was requested and granted

allowing the data collection process to continue until August 11, 2025.

Response Rate

Over the 19-month data collection period response rates ranged from 0 responses per month to 31 responses per month, with an average response rate of two per month. The total number of participants that completed the survey (63) was less than the original minimum of 85 participants recommended by the G*power analysis. Additional post-hoc analysis was completed to gain an understanding of the impact of the smaller sample size on the study analysis and results. The details of this post-hoc analysis are presented in the Results section. Since data collection was continuing for an extended period of time, I gained approval from the IRB and both of my committee members to end data collection and move forward with data analysis.

Descriptive and Demographic Characteristics

The study participants included 63 actively practicing master's level mental health clinicians within the United States who have 6 or more months of experience working with children ages 17 and younger. Table 1 displays the age range of the 63 respondents with 32-41 being the largest represented age range containing 38% of all participants.

Table 1

Participant Age Range

Age Range in Years	<i>n</i> *	Percentage
22-31	16	25.40%
32-41	24	38.10%
42-51	13	20.63%
52-61	8	12.70%
62-71	2	3.17%

Note. **N* = 63

In the present study all participants, 63, identified both their gender identity and their current anatomical sex which can be seen in Table 2. When asked about participant gender identity at the time of the study, eight identified as male, 51 identified as female, and seven identified in the other gender identity category and indicated genders of non-binary, agender, transgender, gender fluid and trans masculine. Additionally, all participants were asked to identify their ethnicity/race, which can be seen in Table 3.

Table 2

Participant Gender and Sex

Demographic Variable	<i>n</i> *	Percentage
Anatomical Sex		
Male	8	12.70%
Female	54	85.71%
Both male and female	1	1.59%
Gender Identity		
Male	5	7.94%
Female	51	80.95%
Other	7	11.11%

Note. **N* = 63

Table 3

Participant Ethnicity/Race

Ethnicity/Race	<i>n</i> *	Percentage
White/Caucasian	47	74.60%
Hispanic, Latino or Spanish	3	4.76%
African American/black,	6	9.52%
American Indian/Alaskan native	1	1.59%
Biracial	4	6.35%
Other	2	3.17%

Note. **N* = 63

Table 4 displays the participants geographical area within the United States in which they currently provide counseling services. Of the 63 participants most were in the Western region of the United States (77.78%). Table 5 displays the geographical region of the participants graduate degree program within the United States. Although there were some differences between these geographic locations for clinical practice, the majority of the 63 participants attended graduate school in the western region of the United States (68.25%).

Table 4

Participant Geographical Area of Clinical Practice

Geographic Region	<i>n</i> *	Percentage
Northeast	1	1.59%
Southeast	7	11.11%
Midwest	2	3.17%
Southwest	4	6.35%
West	49	77.78%

Note. **N* = 63

Table 5

Participant Graduate Education Geographical Area

Geographic Region	<i>n</i> *	Percentage
Northeast	6	9.52%
Southeast	6	9.52%
Midwest	3	4.76%
Southwest	5	7.94%
West	43	68.25%

Note. **N* = 63

Participants were also asked about their licensure status (see Table 6). Further, participants were asked to identify aspects of their clinical experience across their career. Table 7 displays the participants' years of clinical experience. Most participants indicated

having 1 to 5 years of clinical experience (34). Table 8 shows the participants' average caseload size carried across their career, with the highest number of clinicians identifying a caseload size between 21 and 30 clients. Participants were asked to identify which type of practice setting they have worked at the most across their career. Table 9 displays a breakdown of the participants identified practice settings. Most participants (36) identified as working in community mental health agencies.

Table 6

Participant License Type

License Type	<i>n</i> *	Percentage
Licensed mental health counselor	21	33.33%
Licensed mental health counselor associate	11	17.46%
Licensed practical counselor	5	7.94%
Marriage and family therapist	1	1.59%
Licensed clinical social worker	9	14.29%
Licensed clinical social worker associate	9	14.29%
Agency affiliated counselor	1	1.59%
Other	6	9.52%

Note. **N* = 63

Table 7

Participant Years of Clinical Practice

Years of Counseling Experience	<i>n</i> *	Percentage
1 or less	3	4.76%
1-5	34	53.97%
6-10	11	17.46%
11-15	7	11.11%
16-20	6	9.52%
21-25	1	1.59%
26 or more	1	1.59%

Note. **N* = 63

Table 8*Participant Average Caseload Size*

Average Caseload Size	<i>n</i> *	Percentage
1-10	2	3.17%
11-20	9	14.29%
21-30	25	39.68%
31-40	8	12.70%
41-50	10	15.87%
51-60	3	4.76%
More than 60	6	9.52%

Note. **N* = 63

Table 9*Participant Practice Setting*

Practice Setting	<i>n</i> *	Percentage
Private practice	8	12.70%
School or university	9	14.29%
Hospital	3	4.76%
Psychiatric hospital	4	6.35%
Jail, prison or other institute of facility	1	1.59%
Community mental health agency	36	57.14%
Community agency (non mental health focus)	2	3.17%

Note. **N* = 63

Participants disclosed their personal status related to sexual trauma and PSB history for both them and close friends and family members. Four demographic questions were used to assess this, and all participants (63) responded to each of the questions. Table 10 displays the participants' responses related to sexual trauma history. Participants reported high rates of sexual trauma history for both them and close friends and family with 52.38% of participants reporting a personal sexual trauma history and 82.54% of participants reporting having a close family member or friend with a personal sexual trauma history. Table 11 displays the participants' responses related to personal PSB

history. Participants reported significant rates of personal PSB history for both them and close friends and family with 11.11% of participants reporting a personal PSB history and 31.75% of participants reporting having a close family member or friend with a personal PSB history.

Table 10

Participant Personal Sexual Trauma History

Sexual trauma history	<i>n</i> *	Percentage
Self		
Yes	33	52.38%
No	30	47.62%
Family member or friend		
Yes	52	82.54%
No	11	17.46%

Note. **N* = 63

Table 11

Participant Personal Problematic Sexual Behavior History

Personal PSB history	<i>n</i> *	Percentage
Self		
Yes	7	11.11%
No	56	88.89%
Family member or friend		
Yes	20	31.75%
No	43	68.25%

Note. **N* = 63

Demographics were collected to determine participants' history of treating clients who present to counseling services to address PSB. Participants were asked about their treatment history for adults, adolescents, and children who present to treatment to address PSB. Table 12 displays the number of PSB clients' participants endorsed treating across their career. Participants reported that 57.14% (36) had a history of treating an adult PSB

client, 68.25% (43) reported a history of treating an adolescent PSB client and 60.32% (38) reported a history of treating a child PSB client.

Participants were asked to indicate how many adult, adolescent and child clients they treated across their career who presented to treatment with PSB. These rates are represented in Table 13. When analyzing participants treatment of adults who present to treatment with PSB 34.92% of participants endorsed treating 51 or more across their career, 44.44% of participants endorsed treating 51 or more adolescents who present to treatment with PSB and 41.27% of participants endorsed treating 51 or more children who present to treatment with PSB across their career.

Table 14 displays participants self-reported rates of addressing PSB in treatment when working with children ages 12 and younger who present to treatment for PSB. Participants could indicate that they addressed the PSB in treatment, somewhat addressed it during treatment or did not address it in treatment. The responses indicate that 47.62% of participants (30) did not address PSB in treatment for clients aged 12 and younger who present to treatment with PSB related concerns.

Table 12*Participant Problematic Sexual Behavior Treatment History*

PSB Treatment History	<i>n</i> *	Percentage
Adults		
Yes	36	57.14%
No	25	39.68%
Unsure	2	3.17%
Adolescents		
Yes	43	68.25%
No	20	31.75%
Unsure	0	0.0%
Children		
Yes	38	60.32%
No	22	34.92%
Unsure	3	4.76%

Note. **N* = 63

Table 13*Number of Problematic Sexual Behavior Clients Treated*

Number Treated	<i>n</i> *	Percentage
Adults		
0	1	1.59%
1-10	20	31.75%
11-20	9	14.29%
21-50	11	17.46%
51 or more	22	34.92%
Adolescents		
0	0	0.00%
1-10	7	11.11%
11-20	9	14.29%
21-50	19	30.16%
51 or more	28	44.44%
Children		
0	5	7.94%
1-10	13	20.63%
11-20	6	9.52%
21-50	13	20.63%
51 or more	26	41.27%

Note. **N* = 63

Table 14*Participant Addressed Child Problematic Sexual Behavior During Treatment*

PSB Addressed	<i>n</i> *	Percentage
Yes	21	33.33%
Somewhat	12	19.05%
No	30	47.62%

Note. **N* = 63

External Validity

The present study evaluated a unique population of actively practicing mental health clinicians within the United States who have had the experience of treating children ages 12 and younger for a minimum of 6 months. As these stated participant inclusion criteria limit the results generalizability to this specific population it is important that the results of the analysis are only applied to this population as they are interpreted and conclusions drawn. A thorough demographic survey was included as part of the study to evaluate the representative population.

Results

Descriptive Statistics

The present study analyzed all predictor and outcome variables for central tendency, standard deviation and variable minimum and maximum scores. Table 15 provides an overview of the results of the descriptive statistics for each variable.

Table 15*Variable Descriptive Statistics*

Variable	Mean	SD	Minimum	Maximum
DoS	4.29	0.60	2.55	5.50
SISE	74.25	7.65	55.00	88.00
Sexual comfort	48.40	8.84	25.00	63.00
Sexual education and training	7.68	2.98	2.00	14.00
Willingness to treat	16.17	5.61	4.00	24.00

Prior to completing the multiple linear regression analysis correlations were completed among all predictor and outcome variables. Table 16 displays the results of the correlation analysis. The results indicated that there were significant positive correlations present between both SISE, $r(61)=.38, p=.001$, and sexual comfort, $r(61)=.45, p=.000$, with the outcome variable of willingness to treat children who exhibit PSB.

Table 16*Overview of Pearson Correlations*

Predictor Variable	Willingness to Treat PSB
DoS	.05
SISE	.38*
Sexual comfort	.45*
Sexual education and training	.18

Note. * $p < .01$

Assumptions

Prior to conducting the multiple regression analysis, multicollinearity among the four predictor variables, DoS, SISE, Sexual Comfort, and sexuality specific education and training, was evaluated using Pearson correlations, tolerance values, and variance inflation factors (VIF). As shown in Table 17, none of the intercorrelations exceeded the

conventional threshold of .70, suggesting acceptable levels of shared variance (Tabachnick & Fidell, 2019). The highest correlation was observed between SISE and sexual comfort ($r = .56, p < .01$), which is considered moderate and not indicative of redundancy (Cohen, 1988).

Collinearity diagnostics further supported the absence of multicollinearity concerns. Tolerance values ranged from .61 to .90, all well above the recommended minimum of .20 (Menard, 1995). Corresponding VIF values ranged from 1.12 to 1.64, remaining below the commonly cited cutoff of 5 (Hair et al., 2019). These findings indicate that the predictor variables were sufficiently distinct and appropriate for inclusion in the regression model.

Table 17

Intercorrelations and Collinearity Diagnostics for Predictor Variables

Predictor Variable	1	2	3	4	Tolerance	VIF
1.DoS	1.00	.05	-.13	.23	.90	1.12
2.SISE	.05	1.00	.56*	.00	.66	1.53
3.Sexual comfort	-.13	.56*	1.00	.19	.61	1.64
4.Sexual education and training	.23	.00	.19	1.00	.87	1.15

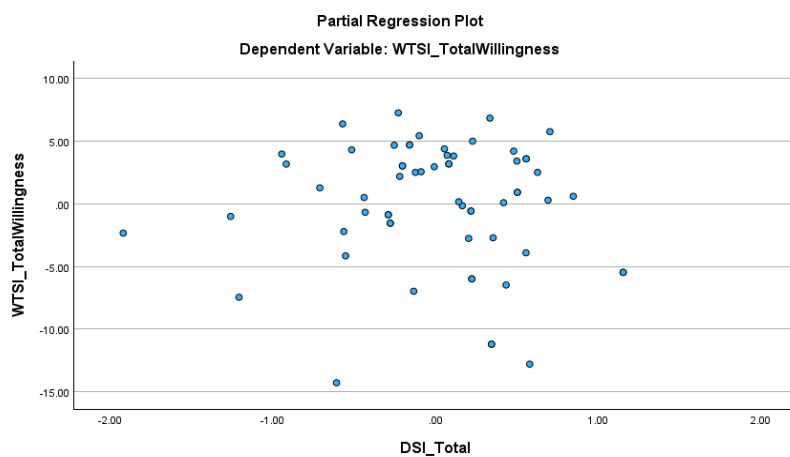
Note. * Correlations are significant at the $p < .01$ level (2-tailed). Tolerance and VIF values indicate no evidence of multicollinearity among predictors

The linear relationship between predictor variables and the outcome variables was assessed using scatterplots. Figure 1 displays the scatterplot for the relationship between DoS and willingness to treat child PSB. Upon visual inspection of the scatterplot, it appeared that no meaningful linear relationship was present. This does not violate this assumption but instead suggests that DoS does not contribute to the model in a

meaningful way when controlling for the other predictor variables. Figure 2 displays the scatterplot for the relationship between SISE and willingness to treat child PSB. Upon visual inspection of the scatterplot, it appeared that there is a mild upward trend where SISE increases as willingness to treat child PSB increases. This indicates that the linearity assumption is met for SISE and it is a valid predictor variable to include in the model. Figure 3 displays the scatterplot for the relationship between sexual comfort and willingness to treat child PSB. Upon visual inspection of the scatterplot, it appeared that there is a strong positive linear relationship between sexual comfort and willingness to treat child PSB, indicating that the linearity assumption for this variable has been met and supporting the inclusion of this predictor in the multiple linear regression model. Figure 4 displays the scatterplot for the relationship between sexuality specific education and training and willingness to treat child PSB. Upon visual inspection of the scatterplot, it appeared that there is no consistent pattern, but the linearity assumption is not violated as there is no curvature or nonlinear pattern present between sexuality specific education and training and willingness to treat child PSB. This indicates that sexuality specific education and training may not be a meaningful predictor variable in the model for the multiple linear regression.

Figure 1

Scatterplot for DoS and Willingness to Treat Child Problematic Sexual Behavior

**Figure 2**

Scatterplot for SISE and Willingness to Treat Child Problematic Sexual Behavior

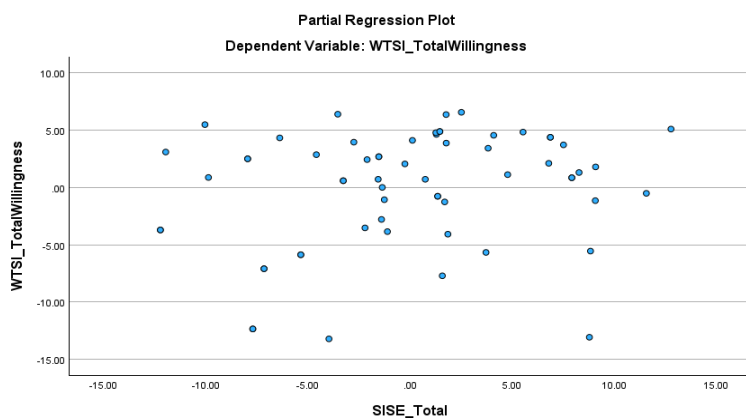
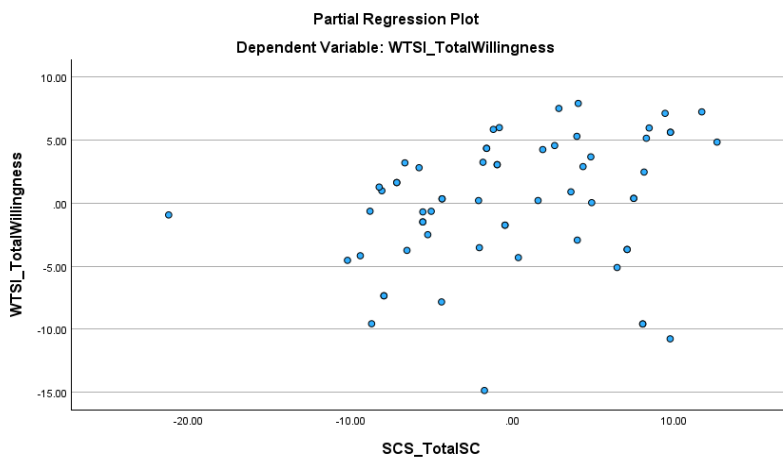
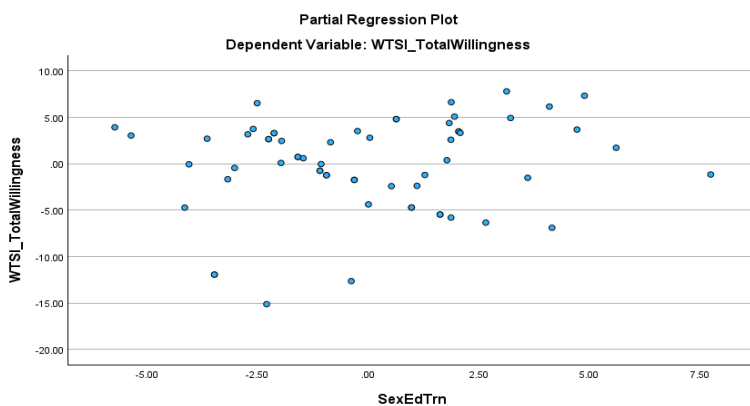


Figure 3

Scatterplot for Sexual Comfort and Willingness to Treat Child Problematic Sexual Behavior

**Figure 4**

Scatterplot for Sexuality Specific Education/Training and Willingness to Treat Child Problematic Sexual Behavior



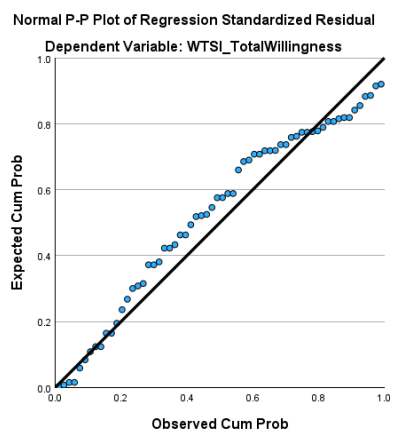
The assumption of multivariate normality that assesses the normal distribution of the standardized residuals was also assessed. This was evaluated through the visual inspection of the P-P plot of the outcome variable residuals. Upon inspection it was

determined that the residuals of the outcome variable appeared linear, see Figure 5. A Q-Q plot of the outcome variable residuals was also visually inspected, and it appeared that the outcome variable appeared normally distributed, see Figure 6. Tests of normality were conducted on the unstandardized residuals. The Kolmogorov-Smirnov test ($D = .127, p = .015$) and Shapiro-Wilk test ($W = .921, p < .001$) both indicated significant deviations from normality, suggesting that the residuals violate the assumption of normal distribution. Despite this finding I continued with the original analysis plan as the Multiple Linear Regression can be effective with data that is not normally distributed (Chatterjee & Hadi, 2012). This departure from normality is somewhat expected given my need to proceed with data analysis with the sample size (63) that was smaller than desired. The assumption of homoscedasticity was also evaluated through the visual inspection of the outcome variable residuals and predicted values via a scatter plot, see Figure 7. Upon inspection no discernible pattern was identified across the data points and the assumption of homoscedasticity was met.

Lastly, the data were assessed to ensure that there was no undue influence from outliers within the data affecting the model. This was assessed through both the evaluation of the standard residuals and Cooks Distance. When evaluating the standardized residuals, none of the standardized residuals were outside of the range of ± 3 , which indicates no presence of outliers. The value for Cooks Distance was well below the cutoff of 1, indicating that no cases had an undue effect on the accuracy of the model.

Figure 5

P-P Plot for Outcome Variable Standardized Residuals

**Figure 6**

Q-Q Plot for Outcome Variable Standardized Residuals

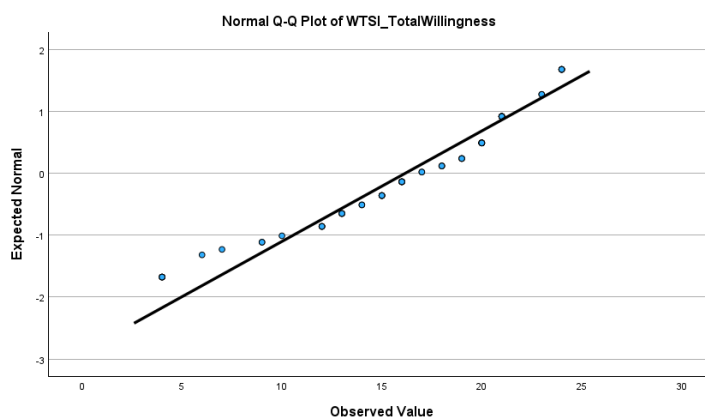
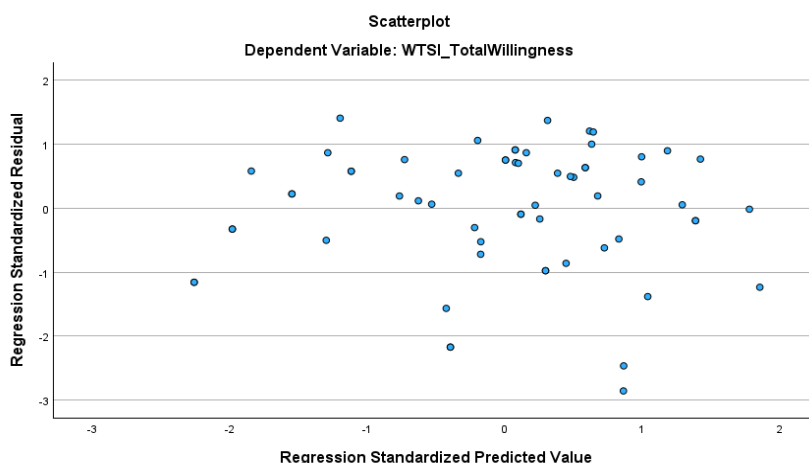


Figure 7

Scatterplot for Outcome Variable Standardized Residuals and Predicted Values



Research Question

A multiple linear regression was conducted using the enter method to assess the extent of the combined and unique relationships between the predictor and outcome variables. This analysis was completed to evaluate the research question.

RQ 1: What is the extent of the combined and unique relationships between mental health clinicians' DoS, SISE, sexual comfort, and amount of sexuality specific education and training, on mental health clinician's willingness to provide treatment to children who exhibit PSB?

H_0 1: There are not significant combined and unique relationships between DoS, SISE, sexual comfort and sexuality specific education and training that affect mental health clinicians' willingness to treat children ages 12 and younger who present to treatment for PSB.

H_{11} : There are significant combined and unique relationships between DoS, SISE, sexual comfort and sexuality specific education and training that affect mental health clinicians' willingness to treat children ages 12 and younger who present to treatment for PSB.

The overall model was significant $F(4, 57) = 4.52, p = .003$ explaining 24.1% ($R^2 = .24$) of the variance of the outcome variable and represents a moderate effect size based on Cohen's (1988) standards. The present study rejects the null hypothesis as there was a statistically significant result indicating that the predictor variables have a combined effect on the outcome variable. DoS, SISE, sexual comfort and amount of sexual education and training have a combined effect on mental health clinicians' willingness to treat children who present to care with PSB.

Despite this result none of the individual predictors had significant effects on the outcome variable independent of the model (see table 20). To assess the magnitude of the effect, Cohen's f^2 was calculated using the formula $f^2 = R^2 / (1 - R^2)$. The resulting effect size was $f^2 = .317$, indicating a medium-to-large effect according to Cohen's (1988) guidelines.

Partial correlations were examined to assess the unique contribution of each predictor while controlling for the others. Sexual comfort was the strongest unique predictor of willingness to treat child PSB, with a partial correlation of $r = .25, p = .057$. SISE showed a moderate positive partial correlation ($r = .21$), though it did not reach statistical significance ($p = .118$). DoS was not a significant predictor ($r = -.05, p = .709$), nor was sexuality specific education and training ($r = .14, p = .275$). These findings

suggest that sexual comfort may play a meaningful role in the willingness of mental health clinicians' treatment of child PSB even when accounting for other psychosocial factors.

A post hoc power analysis was conducted using G*Power with an alpha level of .05, an effect size (f^2) of .317 (large effect, Cohen 1988) and a sample size of 63, indicated a power of .95. The large effect size indicates the predictor variables have a large effect on the outcome variable and the power suggests that the power is high. This analysis implies there is a minimal risk for type II error to occur despite the small sample size.

Table 18

Model Summary for DoS, SISE, Sexual Comfort, Sexuality Education and Training and Willingness to Treat Child PSB

Model	<i>R</i>	R^2	Adjusted R^2	SE	F	df1	df2	<i>p</i>
1	.49	.24	.18	5.09	4.52	4	57	.003

Table 19

ANOVA Statistics for DoS, SISE, Sexual Comfort, Sexuality Education and Training and Willingness to Treat Child PSB

Model	Sum of Squares	<i>df</i>	Mean Square	<i>F</i>	<i>p</i>
Regression	468.24	4	117.06	4.52	.003
Residual	1477.46	57	25.92		
Total	1945.69	61			

Table 20

Coefficients for DoS, SISE, Sexual Comfort, Sexuality Education and Training and Willingness to Treat Child PSB

Variable	B	SE B	β	<i>t</i>	<i>p</i>	95% CI	
						LL	UL
(Constant)	-5.27	7.82	-	-0.67	.50	-20.94	10.39
DoS	-0.43	1.14	-.05	-0.38	.71	-2.72	1.86
SISE	0.17	0.11	.23	1.59	.12	-.04	.38
Sexual comfort	0.18	0.09	.29	1.94	.06	-.01	.37
Sexual education and training	0.26	0.23	.14	1.10	.28	-.21	.73

Second Multiple Linear Regression

A second multiple linear regression analysis was conducted including SISE and sexual comfort as predictors of clinician willingness to treat child PSB. Previously analyzed assumptions and model results indicated SISE and sexual comfort as the likely contributing predictors of the model, given they were significantly correlated with the outcome variable separately. The overall model was significant $F(2, 59) = 8.54, p < .001$ explaining 22.4% ($R^2 = .23$) of the variance of the outcome variable which represents a moderate effect size based on Cohen's (1988) conventions. The present study rejects the null hypothesis as there was a statistically significant result indicating that the predictor variables of SISE and sexual comfort have an effect on the outcome variable.

Each predictor variable was evaluated for its effects on the outcome variable independent of the model. SISE was not found to be a significant contributor to the model ($p = .16$), while sexual comfort was a significant unique predictor ($p = .02$). See Table 23. To assess the magnitude of the effect, Cohen's f^2 was calculated using the formula $f^2 = R^2$

$f^2 = .289$). The resulting effect size was $f^2 = .289$, indicating a medium-to-large effect according to Cohen's (1988) guidelines.

Partial correlations were examined to assess the unique contribution of each predictor while controlling for the others. Sexual comfort was the strongest unique predictor of willingness to treat child PSB, with a positive moderate partial correlation of $r = .28, p = .018$ indicating that increased sexual comfort is associated with increased clinician willingness to treat child PSB. A partial correlation for SISE $r = .16 (p = .16)$ was observed, indicating a weak positive association that did not reach statistical significance. While not conclusive, this trend may warrant further investigation in larger or more targeted samples. These findings suggest that sexual comfort plays the most meaningful role in the model with potential impact on increasing the willingness of mental health clinicians' treatment of child PSB even when accounting for other psychosocial factors.

A post hoc power analysis was conducted using G*Power with an alpha level of .05, an effect size (f^2) of .289 (large effect, Cohen 1988) and a sample size of 63, indicated a power of 0.97. The moderate to large effect size indicates the predictor variables have a large effect on the outcome variable and the power suggests that the power is high. This analysis implies there is a minimal risk for type II error to occur.

Table 21

Model Summary for SISE, Sexual Comfort and Willingness to Treat Child PSB

Model	R	R^2	<i>Adjusted R^2</i>	SE	F	df1	df2	p
1	.47	.22	.20	5.06	8.54	2	59	.001

Table 22*ANOVA Statistics for SISE, Sexual Comfort and Willingness to Treat Child PSB*

Model	Sum of Squares	<i>df</i>	Mean Square	<i>F</i>	<i>p</i>
Regression	436.64	2	218.32	8.54	<.001
Residual	1509.056	59	25.58		
Total	1945.69	61			

Table 23*Coefficients for SISE, Sexual Comfort and Willingness to Treat Child PSB*

Variable	B	SE B	β	<i>t</i>	<i>p</i>	95% CI	
						LL	UL
(Constant)	-4.97	6.32	-	-0.79	.44	-17.63	7.68
SISE	0.15	0.10	.20	1.42	.16	-.06	.39
Sexual comfort	0.22	0.09	.34	2.43	.02	.04	.39

Post hoc Demographic Comparisons

Post hoc demographic analysis were conducted on several key demographic questions (Whether or not mental health clinicians had ever seen children with PSB in their practice, mental health clinicians personal history of sexual trauma and child PSB and mental health clinicians close family and friend history with sexual trauma and PSB) to investigate whether or not the variables displayed any significant relationships with clinician willingness to treat child PSB. Independent samples *t* tests were used for dichotomous demographic variables. Only respondents who selected “Yes” or “No” to whether they had been exposed to child PSB cases in their practice were included in the post hoc demographic analysis. Participants who selected “unsure” were excluded due to insufficient sample size ($N = 3$).

Exposure to Child PSB Cases

An independent samples t-test (see table 24) was conducted to examine differences in mental health clinicians' willingness to treat children with PSB based on whether they had previously been exposed to child PSB clients in their clinical practice. Levene's test for equality of variances was not significant, $F(1, 58) = 0.007, p = .933$, indicating that the assumption of equal variances was met.

The results revealed a statistically significant difference in willingness to treat scores between clinicians who had been exposed to child PSB in their practices and those who had not, $t(58) = 2.58, p = .012$ (two-tailed). Clinicians who had previously been exposed to child PSB cases reported significantly higher willingness scores (M difference = 3.77, $SE = 1.46$), with a 95% confidence interval ranging from 0.84 to 6.70. These findings suggest that actual clinical exposure to child PSB is associated with greater reported willingness to treat this population. The "Unsure" group ($N = 3$), was excluded from this analysis as it had too low of a response rate to correctly analyze and interpret.

Table 24

Independent Samples T Test for Exposure to Child PSB Cases

Exposed to PSB Cases	<i>n</i>	<i>M</i>	<i>SD</i>	<i>t</i>	<i>df</i>	<i>p</i>	95% <i>CI</i>	
							<i>LL</i>	<i>UL</i>
Yes	38	17.50	5.44	2.58	58	.01	.84	6.70
No	22	13.73	5.50			.		

Note. Levene's test for equality of variances was not significant, indicating equal variances across groups. "Unsure" responses were excluded due to low sample size ($N = 3$).

Sexual Trauma and Childhood PSB History

An independent samples *t* test (Table 25) was conducted to compare willingness scores between clinicians with and without a history of sexual trauma. There was no significant difference in willingness to treat child PSB scores for clinicians with trauma history ($M = 15.78, SD = 5.17$) and those without ($M = 16.63, SD = 6.11$); $t(61) = -0.62, p = .54, 95\% CI [-3.72, 1.97]$. A second independent samples *t*-test was conducted to examine differences in willingness scores between clinicians who reported having a close friend or family member with a history of sexual trauma and those who did not. There was no significant difference in willingness scores for clinicians with a close contact history ($M = 16.06, SD = 5.84$) and those without ($M = 16.73, SD = 4.52$); $t(61) = -0.36, p = .72, 95\% CI [-4.42, 3.08]$.

Table 25

Independent Samples T Test for Willingness to Treat PSB by Sexual Trauma History

Trauma History	<i>n</i>	<i>M</i>	<i>SD</i>	<i>t</i>	<i>df</i>	<i>p</i>	95% CI	
							LL	UL
Personal								
Yes	33	15.78	5.17	-0.62	61	.54	-3.72	1.97
No	30	16.63	6.11					
Family/Friend								
Yes	52	16.06	5.84	-0.36	61	.72	-4.42	3.08
No	11	16.73	4.52					

Additional independent samples *t*-tests (table 26) were conducted to evaluate mental health clinician personal and close family/friend history of childhood PSB as it relates to their willingness to treat child clients who exhibit PSB. An independent samples *t*-test was conducted to examine differences in willingness scores between

clinicians who reported a history of PSB and those who did not. There was no significant difference in willingness scores for clinicians with a history of personal PSB ($M = 17.57$, $SD = 5.71$) and those without ($M = 16.00$, $SD = 5.62$); $t(61) = 0.70$, $p = .49$, 95% CI [-2.94, 6.08]. An additional independent samples t-test was conducted to examine differences in willingness scores between clinicians who reported having a close friend or family member with a history of PSB and those who did not. There was no significant difference in willingness scores for clinicians with a close contact with PSB history ($M = 15.10$, $SD = 6.52$) and those without ($M = 16.67$, $SD = 5.13$); $t(61) = -1.04$, $p = .30$, 95% CI [-4.61, 1.46].

Table 26

Independent Samples T Test for Willingness to Treat PSB by PSB History

PSB History	<i>n</i>	<i>M</i>	<i>SD</i>	<i>t</i>	<i>df</i>	<i>p</i>	95% CI	
							LL	UL
Personal								
Yes	7	17.57	5.71	0.70	61	.49	-2.94	6.08
No	56	16.00	5.62					
Family/Friend								
Yes	20	15.10	6.52	-1.04	61	.30	-4.61	1.46
No	43	16.67	5.13					

Summary

This study examined factors influencing mental health clinicians' willingness to treat children (ages 12 and under) with PSB. While the full regression model showed a significant overall relationship between predictors (DoS, SISE, Sexual Comfort, and sexuality-specific training), none had a unique individual effect. A refined model including only Sexual Comfort and SISE was statistically significant, with Sexual

Comfort emerging as the sole predictor of the outcome variable. Clinicians with prior exposure to child PSB cases were more willing to treat this population. Personal trauma and PSB history were common but not predictive. Findings suggest that sexual comfort and clinical exposure to child PSB cases may be key drivers of treatment willingness.

Chapter 5 will provide an overview of the purpose of the study and a concise interpretation of the findings from this analysis. The chapter will also discuss how the findings intersect with the theoretical framework. Limitations of the study, including generalizations, validity, and reliability will also be discussed. Future research recommendations will be given on how additional studies can develop the understudied topic of child PSB and factors that affect mental health clinicians' willingness to treat this underserved population. Lastly, implications for methodological and theoretical positive social change, and current practice integrations will be discussed.

Chapter 5: Discussion, Conclusions, and Recommendations

Chapter 5 synthesizes the investigation into the effects of mental health clinicians' characteristics and training on their willingness to treat children with PSB, addressing a gap in the literature. Results of the multiple linear regressions are discussed and examined for their implications on the theoretical framework of the study. This chapter also addresses key findings, reaffirms the study's contribution to addressing the research gap, and evaluates its impact on positive social change. Recommendations for implementation and future research are presented as well as a reflection on the study's broader implications for academic discourse and interventions in both academic and clinical mental health settings.

Previous academic literature has identified that over 30% of CSA occurs when other children exhibit PSB (Finkelhor et al., 2009). Although this has been a known area of concern, the literature has focused on preventing CSA through addressing treatment for adult and adolescent perpetrators of CSA or has focused on therapeutic interventions related to recovery for the children who have already experienced CSA. There has been a recognized need for further information related to the population of PSB in children (Jenkins et al., 2020). The research that has been completed around child PSB has been qualitative in nature and identified themes of children with PSB not being able to access effective treatment to address the PSB in their communities and a lack of mental health clinician willingness to treat PSB in children ages 12 and younger (Belluardo-Crosby, 2011; Jenkins et al., 2020; Malvaso et al., 2019; McKibbin, 2017; Shields et al., 2020, Shields et al., 2018; Taylor et al., 2020; Tener et al., 2019).

The present study sought to provide foundational information around what variables might impact mental health clinicians' willingness to work with children who exhibit PSB. Previous academic literature had yet to explore this topic in a direct manner. The purpose of the present study was to be the first quantitative non-experimental survey approach to assess the combined and unique impacts of mental health clinicians' characteristics and education on their willingness to treat children who exhibit PSB. DoS, SISE, sexual comfort and amount of sexuality specific education and training were evaluated as possible predictors of the amount of willingness mental health clinicians had to treat this population of children.

The study analyzed survey results of 63 mental health clinicians from across the United States, which included analysis of demographic information and questionnaires to assess the participants DoS, SISE, sexual comfort, amount of sexuality specific training and education, and amount of willingness to treat children with PSB. A multiple linear regression of the model and descriptive statistics of the demographic information were analyzed to assess the population and research question. Demographics of the sample of mental health clinicians indicated that participants had significant rates of personal history of sexual trauma and childhood PSB for both themselves and close friends and family members. However, those specific characteristics did not show a significant relationship with mental health clinicians' willingness to treat child PSB. It was also revealed that most mental health clinicians had encountered children with PSB in their practice settings, but close to half of the participants who endorsed this reported that they did not provide any treatment surrounding the PSB. Further analysis of the demographics

indicated that clinicians were more willing to treat child clients with PSB when they had prior exposure to child PSB cases.

Key findings from the multiple linear regression indicated that the predictor variables of DoS, SISE, sexual comfort and amount of sexuality specific education and training had a significant combined effect on the amount of willingness participants had to treat children with PSB. However, none of the predictors were significant when evaluated for their independent contribution to the model controlling for all others. Therefore, a second model was tested excluding the variables that were not correlated with the outcome variable separately (zero order correlations). The refined model included sexual comfort and SISE as the predictor variables. Sexual comfort was identified as the sole predictor of mental health clinicians' willingness to treat child PSB.

Interpretation of Findings

Sexual comfort emerged as the most robust predictor of willingness to treat, suggesting that clinicians who are more at ease with sexual content, including developmentally atypical or socially sensitive topics such as child sexuality, may be better equipped to engage therapeutically with children exhibiting PSB. This finding aligns with Anderson's (1986) staged model of therapist comfort, which posits that emotional readiness develops through progressive exposure and reflection. Graham and Smith (1984) further operationalized sexual comfort as a multidimensional construct, emphasizing its relevance for educators and clinicians navigating sensitive sexual topics. In total, Graham and Smith identified four dimensions of sexual comfort relevant to professional practice which include: cognitive comfort (confidence in one's sexual

knowledge and beliefs), emotional comfort (ability to regulate affective responses to sexual content), behavioral comfort (willingness to engage in sexual discussions or interventions), and interpersonal comfort (capacity to navigate sexual topics within relational and cultural boundaries). These dimensions reflect not only personal readiness but also professional effectiveness, as discomfort may inhibit both clinical engagement and broader participation in education or research.

These results extend the work of Miller and Byers (2012), who found that sexual comfort and SISE (a clinician's confidence in their ability to address sexual issues with clients) were significant predictors of psychologists' willingness to treat sexual issues in adult populations. Hanzlik and Gaubatz (2012) similarly reported that clinical trainees often feel unprepared to address sexual content, despite recognizing its importance, reinforcing the need for experiential learning and supervision that directly target sexual comfort. Harris and Hays (2008) emphasized that clinicians' ability to maintain therapeutic neutrality when discussing sexual topics reflects not only technical skill but also emotional maturity and boundary clarity. In this study, sexual comfort may serve as a practical expression of applied differentiation, allowing clinicians to remain emotionally grounded and professionally attuned even when client disclosures evoke discomfort or challenge deeply held beliefs.

Taken together, the academic literature and the present study findings suggest that sexual comfort may not be merely a passive tolerance of sexual topics but an active stance rooted in self-awareness, emotional regulation, and clinical presence. This capacity becomes especially critical when treating children or families affected by PSB,

where clinicians must navigate complex ethical situations without allowing personal reactions to interfere with clinical judgment (Kenny & Wurtele, 2023). Although sexual comfort and DoS were not correlated in this study, previous research has shown associations between clinician comfort and differentiation constructs, particularly in contexts involving stigmatized or emotionally charged topics (Kenny & Wurtele, 2023). One possible explanation for the lack of findings here is the use of the total DoS score rather than its subscales, which may have obscured more subtle relationships.

This study contributes to the academic literature on CSA prevention by shifting the focus toward early intervention with child PSB cases and clinician preparedness through the cultivation of sexual comfort. It invites academic and clinical communities to reimagine treatment pathways that are not only evidence-based but also emotionally attuned to the factors influencing clinician engagement in complex treatment areas—creating a framework for a proactive, trauma-informed response to CSA.

Demographic Insights and the Role of Lived Experience

Demographic data offered a nuanced view of the clinician sample, revealing significant prevalence rates of personal history with sexual trauma (52% personal history, 83% close relationship history) and childhood PSB (11% personal history, 32% close relationship history). However, these lived experiences did not significantly predict willingness to treat child PSB, suggesting that personal trauma history alone may not drive clinical avoidance. Instead, prior professional exposure to PSB cases was associated with increased willingness, reinforcing the value of experiential learning in shaping clinician readiness. This finding aligns with Hanzlik and Gaubatz (2012), who reported

that trainees often feel unprepared to address sexual issues due to limited exposure, despite personal experience or general awareness. Similarly, Harris and Hays (2008) emphasized that comfort discussing sexual content is more strongly linked to professional experience and supervisory support than to personal background. These studies support the interpretation that sexual comfort is cultivated through structured clinical exposure, not automatically conferred by lived experience.

Interestingly, these results diverge from Chaffin et al. (2009), who found countertransference to be a non-significant factor in treating adult and adolescent PSB cases. In contrast, the present study's demographic data, exhibiting participants high rates of personal and close family/friend history of sexual trauma and PSB, suggest that countertransference may warrant renewed evaluation in the context of child PSB treatment engagement. While such histories did not predict treatment willingness in this sample, their high prevalence raises important questions about how trauma or PSB history might influence clinical decision-making in more subtle ways. As Harris et al. (2020) noted, clinicians' ability to maintain therapeutic neutrality when addressing sexual content reflects a deeper capacity for emotional regulation and boundary clarity, both central to Bowen's concept of DoS (Bowen, 1978; Kerr & Bowen, 1988).

Theoretical Implications

The findings of this study offer meaningful insight into how clinician characteristics intersect with Bowen's family systems theory, particularly through the lens of sexual comfort and DoS. While DoS did not emerge as a statistically significant standalone predictor of willingness to treat children with PSB, the broader theoretical

framework remains relevant in understanding the emotional processes that shape clinician decision-making. Bowen emphasized emotional regulation, boundary clarity, and self-awareness as essential for navigating complex relational systems (Bowen, 1978; Kerr & Bowen, 1988), qualities conceptually aligned with those observed in clinicians who reported greater willingness to treat, higher sexual comfort and prior exposure to child PSB cases.

Limitations

The present study encountered several limitations that warrant careful consideration when interpreting its findings. Foremost among these is the small sample size ($N = 63$), which fell significantly short of the 85 participants recommended by the initial G*Power analysis based on the inclusion of four predictor variables. Although a post-hoc power analysis indicated adequate statistical power, it remains possible that a larger sample would have yielded different results. The low response rate caused some demographic subcategories to be excluded from analysis due to a low N , which indicated that it would not have been appropriate to include the subcategories in the variables analysis. The reduced sample size may have impacted key assumptions of multiple linear regression, particularly the assumption of normality for the outcome variable. In this study, scores for clinicians' willingness to treat children with PSB were not normally distributed, due to high mean scores they were skewed to the right. While multiple linear regression is generally robust to minor violations of normality, a larger sample may have resulted in a more normally distributed outcome variable, potentially altering the statistical significance and interpretation of the model. Future research may consider

whether predictor variables related to sexuality function more effectively as mediators or moderators of clinician willingness to treat, especially in larger or more diverse samples. Additionally, although prior experience treating children who exhibit PSB may provide useful insight into clinician behavior, this demographic variable was excluded from inferential analysis due to its conceptual overlap with the outcome variable (willingness to treat), which could have confounded interpretation of predictor effects

Limitations related to study design also merit attention. The use of multiple inclusion criteria, specifically targeting master's-level mental health clinicians practicing in the United States with at least six months of experience working therapeutically with children, resulted in a highly specific sample. While this specificity enhanced internal validity, it limits the generalizability of the findings to broader populations of clinicians who may work with children exhibiting PSB but do not meet these criteria. Moreover, three of the four predictor variables (SISE, sexual comfort, and sexuality-specific education and training) were conceptually linked to sexuality, raising the possibility of construct overlap. Although no violations of multicollinearity were violated amongst the predictors with conceptual overlap (sexuality-based predictor variables), the small sample size may have limited the power to detect significant independent relationships between predictors and the outcome variable. Future research with a larger sample may provide clearer insight into the distinct roles these variables play and whether some may function better as mediators or moderators within a broader model. For example, the SISE questionnaire includes subscales related to sexual comfort and sexuality knowledge self-efficacy, which may overlap with the independent measures of sexual comfort and

sexuality-specific education. In addition, the measure used to assess willingness to treat may have introduced bias due to its limited number of scale items (4 items), possible redundancy between items, and lack of specificity in language regarding PSB in youth. The relatively high mean score also suggests a potential ceiling effect, which may have limited the variability in responses and reduced the model's explanatory power. These measurement limitations highlight the need for more targeted, psychometrically robust instruments in future research.

The sensitive nature of the study's subject matter, sexuality and children, introduces additional limitations. Prior research indicates that individuals may be reluctant to respond openly or accurately to questions involving stigmatized or emotionally charged topics (Wurtele & Kenny, 2022). Mental health clinicians, in particular, may experience internal conflict when asked to disclose discomfort or reluctance to treat vulnerable populations such as children. Given the professional expectation of neutrality and nonjudgment, participants may have experienced guilt or shame when endorsing negative attitudes or hesitancy, potentially leading to overreporting of willingness to treat (Kenny & Wurtele, 2023). Importantly, none of the instruments used in this study included measures of social desirability, leaving open the possibility that participants' responses were influenced by a desire to present themselves in a socially acceptable light.

Limitations also emerged in the data collection process. Recruitment occurred over a 19-month period (2023–2025), which is unusually long given the small sample size. It is possible that societal changes during this extended timeframe influenced

participant attitudes and responses, introducing temporal variability that may have affected the consistency of the data. Additionally, the sample was predominantly female and Caucasian, which limits the representativeness of the findings to other demographic groups within the master's-level mental health clinician population. Future studies should aim for greater demographic diversity to better capture the range of perspectives and experiences relevant to treating children with PSB.

An additional observation emerged during data collection: despite the study's online format and extended 19-month recruitment period, only 63 participants completed the survey, well below the 85 recommended by G*Power analysis for adequate statistical power (Faul et al., 2009). This limited engagement may reflect broader discomfort or reluctance among clinicians to interact with PSB-related content, echoing the treatment avoidance observed in the study's findings: although most participants reported high levels of sexual comfort and willingness to treat, nearly half (47.62%) had not engaged in treatment with children exhibiting PSB. While recruitment challenges are common in social science research, response rates among mental health clinicians typically range from 20% to 40%, with some studies reporting rates as low as 10–15% depending on recruitment strategy and topic sensitivity (Fall et al., 2022). Even within that context, the extended duration and low yield of this study suggest a potential aversion to the topic itself (Fowler, 2014). Bloom, Gutierrez, and Lambie (2015) similarly found that helping professionals often experience discomfort when confronted with sexually explicit or taboo topics, hypothesizing that such discomfort may inhibit not only clinical engagement and professional behavior but also research participation in sexuality-related

domains.

Importantly, this study also quantifies the presence of children with PSB across diverse practice settings in the United States. Most participants reported treating 51 or more children with PSB over the course of their careers, indicating that this population is not rare but routinely encountered. Prior to this study, no research had attempted to quantify the frequency of such cases or the extent to which clinicians engage in treatment. These findings underscore the urgent need for specialized training and systemic support to ensure that children with PSB receive appropriate and effective care. As Kenny and Wurtele (2023) emphasized, addressing barriers to professional engagement, particularly those rooted in discomfort or lack of training, is essential for expanding access to care and preventing future harm. This study offers an initial glimpse into clinicians' lack of engagement with child PSB cases. These limitations suggest that the findings of the present study should be interpreted with caution. While the results offer valuable preliminary insights into clinicians' willingness to treat children with PSB, further research with larger, more diverse samples and refined measurement tools is needed to confirm and expand upon these findings

Recommendations

The results of this study suggest several important directions for future research on mental health clinicians' willingness to treat children exhibiting PSB. The refined regression model, which included only sexual comfort and SISE, demonstrated a statistically significant relationship, with sexual comfort emerging as the sole individual predictor. This finding underscores the importance of clinicians' comfort with sexual

content in shaping treatment of PSB in children. Future research should further investigate sexual comfort as a central construct, including its development through clinical training, supervision, and experiential learning.

Given that none of the four original predictor variables demonstrated unique individual effects in the original model, future studies should explore alternative analytic strategies. Additionally, subscale analyses of the DoS and SISE instruments may reveal more nuanced relationships that were obscured by reliance on total construct scores. Larger sample sizes would allow for more robust testing of these subscales and improve statistical power. Future studies should also consider using or developing a more comprehensive and validated measure of clinicians' willingness to treat youth with PSB. The use of a scale with more items and clearer focus on this specific clinical population would improve construct validity and allow for more robust conclusions. Such refinement would complement subscale analyses and strengthen the overall measurement framework used in this line of research

The study's demographic findings also point to meaningful directions for future research. While personal histories of sexual trauma and childhood PSB were common among participants, they did not significantly predict treatment willingness. This suggests that lived experience alone may not drive clinical avoidance. However, the high prevalence of these experiences warrants deeper exploration into how personal child PSB and sexual trauma history may influence clinician behavior. Future studies should include validated measures of subject matter avoidance and assess its potential role in shaping attitudes toward child PSB treatment.

To address potential response bias, future studies should incorporate social desirability scales and indirect questioning techniques. Mental health clinicians may feel pressure to present themselves as neutral and nonjudgmental, particularly when asked about willingness to treat vulnerable populations such as children. This dynamic may lead to overreporting of willingness and underreporting of treatment avoidances, which is supported by the studies finding that only half of clinicians who reported exposure to child PSB cases engaged in addressing the PSB as part of the child's treatment. Including tools to assess response bias would strengthen the validity of future findings and provide a clearer picture of clinician attitudes.

Beyond immediate implementation, future research should explore how targeted interventions influence clinicians' long-term willingness to treat child PSB. Longitudinal studies could examine whether increasing sexual comfort through training or supervision leads to sustained changes in clinical engagement. Additionally, qualitative investigations might illuminate the emotional and ethical dimensions of this work, offering deeper insight into the relational and moral complexities clinicians navigate.

Lastly, future studies should aim to increase sample size and demographic diversity. The present study's extended data collection period and modest sample size limited generalizability and may have contributed to assumption violations in the regression analysis. Expanding recruitment efforts across geographic regions, professional roles, and cultural backgrounds would enhance representativeness and allow for more comprehensive modeling of clinician willingness. Future studies with larger samples should also explore differences across all response categories that were excluded

in the present studies demographic analysis to better capture the full spectrum of clinical engagement. Although this study relied on self-report measures, including whether clinicians had previously treated a youth with PSB, this variable may represent a more behaviorally grounded form of willingness. Future research may wish to explore this construct more fully as a potential alternative or supplement to attitudinal self-report measures. Reported behavioral engagement, such as having provided treatment to children with PSB, may serve as a more ecologically valid indicator of clinician willingness than self-reported attitudes alone as focus on a behavioral construct of willingness may better eliminate response bias. Although the present study collected this information from participants as demographic variable future research could expand upon this and consider the use of clinical behavioral engagement with child PSB clients as the outcome variable for willingness to treat. Examining the demographic and professional characteristics of clinicians who have treated this population could offer valuable insight into the factors that support or inhibit real-world service provision. These recommendations emphasize the need for continued research that is methodologically rigorous, emotionally attuned, and clinically relevant. Advancing this field will help ensure that children with PSB receive timely, specialized care and that clinicians are equipped with the training, support, and emotional readiness to provide it.

Implications

The findings of this study offer significant contributions to understanding clinician willingness to treat children with PSB, identifying sexual comfort and clinical exposure as statistically significant predictors. These results suggest that targeted

improvements aimed at increasing clinician sexual comfort and exposure to child PSB cases may support more clinicians in ethically and effectively engaging with this population, thereby informing positive social changes within mental health systems.

In clinical training, the predictive strength of sexual comfort highlights the importance of preparing clinicians to navigate sexual content with confidence and emotional regulation. Graduate programs and clinical internships may consider integrating exercises into curriculum that supports facilitating sexual comfort such as, role-plays and guided discussion to help clinicians build comfort and reduce avoidance. While the study did not evaluate specific training models, the association between exposure and willingness suggests that experiential learning may be a valuable component of clinician development.

In supervision, the findings support the idea that supervisors can play a role in fostering clinician readiness. Supervisors may benefit from tools and frameworks that help them identify sexual discomfort or avoidance related to child PSB cases and facilitate intentional conversations around emotional responses, ethical boundaries, and trauma-informed care. Although supervision practices were not directly measured in this study, the relationship between prior exposure and increased willingness implies that supportive supervision may reinforce clinician engagement with challenging cases.

At the agency level, these results may inform workforce development strategies aimed at increasing access to care for children with PSB. Community mental health agencies might consider policies that promote early exposure to PSB-related cases, offer continuing education on child sexual development, and support supervisors in addressing

clinician sexual discomfort. While broader systemic outcomes were not assessed, increasing clinician willingness could contribute to improved service availability and reduced treatment gaps for this population.

By focusing on measurable predictors of willingness, this study provides a foundation for incremental, evidence-based changes aimed at increasing clinician sexual comfort and exposure to child PSB cases. These changes may help reduce clinician avoidance, improve access to care, and support ethical engagement with children and families impacted by PSB, ultimately advancing a more responsive and prepared mental health workforce.

Highlighting sexual comfort as both a modifiable trait and a theoretical construct, the findings further advance the literature on CSA prevention and clinician preparedness. This dual emphasis reinforces the need for treatment pathways that are not only grounded in empirical evidence but also emotionally attuned to the relational and ethical complexities of CSA and PSB. Together, these insights invite academic and clinical communities to reimagine systems of care that center clinician readiness, emotional safety, and trauma-informed responsiveness, creating a framework for sustained, proactive engagement with children and families navigating sexual trauma.

Conclusion

Children who exhibit PSB and the master's-level mental health clinicians who treat them remain significantly underrepresented in scholarly literature. Yet the need for further investigation in this area is clear, given the impact of child PSB on community safety, family dynamics, CSA, and the broader societal costs associated with untreated

PSB in children (Sites & Widdifield, 2020). Previous research has qualitatively identified barriers to care for children with PSB, particularly the reluctance of clinicians to engage in treatment (Slemaker et al., 2021). The present study builds on that foundation by quantitatively examining clinicians' willingness to treat children with PSB and the individual characteristics and educational factors that influence that willingness. Findings revealed that while mental health clinicians frequently encounter children with PSB in their practice settings, nearly half do not address the behavior in treatment. This confirms that the population of children with PSB is present across diverse clinical environments, yet many do not receive care specific to their presenting problem. The full regression model demonstrated that DoS, SISE, sexual comfort, and sexuality-specific education and training collectively predict clinician willingness to treat child PSB. A refined model including only SISE and sexual comfort revealed sexual comfort as the strongest individual predictor, emphasizing the importance of sexual comfort with the discussion and content of sexuality-related topics and clinical engagement in child PSB cases.

Demographic findings added further insight into these results. Clinicians reported high rates of personal and familial histories of sexual trauma and childhood PSB, though these experiences did not significantly predict treatment willingness. In contrast, prior exposure to child PSB cases was associated with increased willingness to treat future child PSB clients. These findings suggest that clinical exposure and sexual comfort, not personal history, may be key drivers of treatment engagement.

Although the study's small sample size and specific inclusion criteria limit generalizability, the results offer an important first step in understanding barriers to care

for children with PSB. More importantly, this research contributes to the limited literature on children ages 12 and younger who exhibit PSB, establishing a baseline for future inquiry. The prevalence of child PSB in practice settings was notable and reinforces the urgency of continued research into access to care, clinician training, and clinician avoidance related to the topic of childhood PSB. If these areas are better understood, there is a clear pathway to positive social change. Proactive intervention for mild child PSB cases may reduce rates of child-on-child sexual abuse, strengthen family systems, and enhance community safety. These changes have the potential to reduce reliance on higher levels of care and mitigate the long-term costs associated with untreated sexual behavior in children. Ultimately, this study affirms the need for trauma-informed, support for clinicians, with particular emphasis on increasing sexual comfort and clinical exposure to child PSB cases. These efforts are essential to cultivating a more responsive, prepared, and compassionate mental health workforce.

By identifying sexual comfort and clinical exposure as key predictors of treatment willingness, this study offers a practical roadmap for change. When clinicians are equipped with emotional readiness and structured experience to engage with child PSB cases, they are more likely to respond with competence rather than avoidance. This shift from discomfort to engagement has the potential to transform clinical practice, reduce stigma, and expand access to care for a vulnerable and often overlooked population. Positive social change begins with clinician preparedness, and this study lays the groundwork for a more ethical, equitable, and healing-centered response to children and families impacted by PSB.

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Appendix A: Letter to Participants

Subject line:

New SurveyMonkey Questionnaire for Mental Health Clinicians

Email message:

There is a new SurveyMonkey survey available about the experiences of mental health clinicians providing treatment to children ages 12 and younger who present with problematic sexual behavior (PSB) that could help provide more early intervention for children with problematic sexual behavior (PSB) and reduce the prevalence of child to child sexual abuse. For this study, you are invited to answer a questionnaire about your training and education, prospective and clinical experience working with children ages 12 and younger who seek services for Problematic Sexual Behavior (PSB).

About the study:

- One 30-60 minute fully anonymous online questionnaire
- You will receive your typical SurveyMonkey compensation rate for participation in this study.

Volunteers must meet these requirements:

- Be an active Masters level licensed or associate licensed Mental Health Clinician (LPC, LMHC, LICSW, LMFT)
- Currently be living and practicing counseling service in the United States
- Have at least 6 months experience working with children ages 17 and younger

This questionnaire is part of the doctoral study for Debra Elise Hutchison, a Ph.D. student at Walden University. This study will take place during September 2022.

Please click the link below to view the study consent form and begin the questionnaire. You are welcome to forward it to others who might be interested.

Appendix B: Study Demographic Questionnaire

Effects of Differentiation of Self, Sexual Intervention Self-Efficacy, Sexual Comfort and Sexuality Specific Education and Trainings on Mental Health Clinicians Willingness to Treat Children ages 12 and Under Who Present to Treatment for Problematic Sexual Behavior Questionnaire

Demographics

1. Age
 - A) 21 or under
 - B) 22-31
 - C) 32-41
 - D) 42-51
 - E) 52-61
 - F) 62-71
 - G) 72 or older

2. What anatomical sexual organs do you have?
 - A) Male
 - B) Female
 - C) Both Male and Female Sex Organs

3. What gender do you identify as?
 - A) Male
 - B) Female
 - C) Other (please state your gender identity)

4. What is your primary race or ethnicity?
 - A) White or Caucasian
 - B) Hispanic, Latino, or Spanish origin
 - C) Black or African American
 - D) American Indian or Alaska Native
 - E) Native Hawaiian or Other Pacific Islander
 - F) Biracial
 - G) Other race or origin

5. What area of the United States do you currently provide counseling services in?
 - A) Northeast (Maine, Massachusetts, Rhode Island, Connecticut, New Hampshire, Vermont, New York, Pennsylvania, New Jersey, Delaware, Maryland)
 - B) Southeast (West Virginia, Virginia, Kentucky, Tennessee, North Carolina, South Carolina, Georgia, Alabama, Mississippi, Arkansas, Louisiana, Florida)

- C) Midwest (Ohio, Indiana, Michigan, Illinois, Missouri, Wisconsin, Minnesota, Iowa, Kansas, Nebraska, South Dakota, North Dakota)
 - D) Southwest (Texas, Oklahoma, New Mexico, Arizona)
 - E) West (Colorado, Wyoming, Montana, Idaho, Washington, Oregon, Utah, Nevada, California, Alaska, Hawaii)
6. In which geographical area did you live in when you completed your highest level of education?
- A) Northeast (Maine, Massachusetts, Rhode Island, Connecticut, New Hampshire, Vermont, New York, Pennsylvania, New Jersey, Delaware, Maryland)
 - B) Southeast (West Virginia, Virginia, Kentucky, Tennessee, North Carolina, South Carolina, Georgia, Alabama, Mississippi, Arkansas, Louisiana, Florida)
 - C) Midwest (Ohio, Indiana, Michigan, Illinois, Missouri, Wisconsin, Minnesota, Iowa, Kansas, Nebraska, South Dakota, North Dakota)
 - D) Southwest (Texas, Oklahoma, New Mexico, Arizona)
 - E) West (Colorado, Wyoming, Montana, Idaho, Washington, Oregon, Utah, Nevada, California, Alaska, Hawaii)
7. What is your current highest level of completed education?
- A) Associate of Arts (AA)
 - B) Associate of Science (AS)
 - C) Bachelor of Arts (BA)
 - D) Bachelor of Science (BS)
 - E) Master of Science (MS)
 - F) Master of Arts (MA)
 - G) Master of Social Work (MSW)
 - H) Master of Education (Med)
 - I) Master of Business (MBA)
 - J) Maste4r of Philosophy (MPhil)
 - K) Doctor of Philosophy (PhD)
 - L) Doctor of Psychology (PsyD)
 - M) Other (please specify):_____
8. For your highest degree completed: What was the name of your program (Clinical Psychology, Counseling, Social Work, Psychology etc.)?
- _____
9. In what year did you graduate from your highest level of education?
- _____
10. How many courses did you participate in across your educational career that included subject matter related to sexuality?
- A. 0

- B. 1
 - C. 2
 - D. 3
 - E. 4
 - F. 5
 - G. 6 or more
11. What is the current status of your state license for practicing counseling?
- A) Fully Independently Licensed
 - B) Associate License (i.e., Working toward independent licensure post graduate school completion)
 - C) Other (please specify): _____
12. What type of license to practice counseling do you hold?
- A) Licensed Mental Health Counselor (LMHC)
 - B) Licensed Mental Health Counselor Associate (LMHCA)
 - C) Licensed Practical Counselor (LPC)
 - D) Licensed Practical Counselor Associate (LPCA)
 - E) Marriage and Family Therapist (MFT)
 - F) Marriage and Family Therapist Associate (MFTA)
 - G) Licensed Clinical Social Worker (LCSW)
 - H) Licensed Clinical Social Worker Associate (LICSWA)
 - I) Agency Affiliated Counselor (AAC)
 - J) Other (please specify): _____
13. How many post-graduate school sexuality specific trainings (Examples: sexual abuse, problematic sexual behavior, sex addiction, sexual dysfunction, the treatment of sexual abusers etc.) have you attended?
- A) 0
 - B) 1
 - C) 2
 - D) 3
 - E) 4
 - F) 5
 - G) 6 or more
14. What was the name of your school and program for your highest level of education?
-
15. How many years post-graduate school have you actively practiced counseling services?
- A) Less than 1 year
 - B) 1-5

- C) 6-10
 - D) 11-15
 - E) 16-20
 - F) 21-25
 - G) 26 or more
16. On average across your career as a mental health counselor what has been the size of your caseload?
- A) 1 to 10
 - B) 11 to 20
 - C) 21 to 30
 - D) 31 to 40
 - E) 41 to 50
 - F) 51 to 60
 - G) More than 60
17. Across your career as a mental health clinician have you treated an adult with problematic sexual behavior (pornography issues, masturbatory issues, sexuality concerns, sex offenses, sexual dysfunction, sexual dissatisfaction, inappropriate sexual boundaries, any other problematic sexual behavior towards themselves or others)?
- A) Yes
 - B) No
 - C) Unsure
18. Across your career as a mental health clinician have you treated an adolescent (age 13 to 17) with problematic sexual behavior (pornography issues, masturbatory issues, sexuality concerns, sex offenses, sexual dysfunction, sexual dissatisfaction, inappropriate sexual boundaries, any other problematic sexual behavior towards themselves or others)?
- D) Yes
 - E) No
 - F) Unsure
19. Across your career as a mental health clinician have you treated a child (age 12 and under) with problematic sexual behavior (pornography issues, masturbatory issues, sexuality concerns, sex offenses, sexual dysfunction, sexual dissatisfaction, inappropriate sexual boundaries, any other problematic sexual behavior towards themselves or others)?
- G) Yes
 - H) No
 - I) Unsure
20. Across your career as a mental health clinician how many adult clients (18 or

older) have you treated?

- A) 0
- B) 1 to 10
- C) 11 to 20
- D) 21 to 50
- A) 51 or more

21. Across your career as a mental health clinician how many adolescent clients (ages 13 to 17) have you treated?

- F) 0
- G) 1 to 10
- H) 11 to 20
- I) 21 to 50
- B) 51 or more

22. Across your career as a mental health clinician how many child clients (12 or younger) have you treated?

- K) 0
- L) 1 to 10
- M) 11 to 20
- N) 21 to 50
- O) 51 or more

23. If you have treated a client age 12 and younger who presented with any Problematic Sexual Behavior (PSB) did your treatment with the client address the PSB?

- A) Yes
- B) Somewhat
- C) No
- D) N/A

24. Do you have a history of experiencing sexual trauma?

- A) Yes
- B) No

25. Does a close friend or family member have a history of experiencing sexual trauma?

- A) Yes
- B) No

26. Do you have a history of ANY problematic sexual behavior?

- C) Yes

D) No

27. Does a close friend or family member have a history of ANY problematic sexual behavior?

C) Yes

D) No

28. In what setting have you provided most of your counseling services to clients?

A) Private Practice

B) School or University

C) Hospital

D) Psychiatric Hospital


E) Prison, Jail, or other incarceration facility

F) Community Mental Health agency

G) Community Agency (non-mental health focus)

Appendix C: Permissions to use the SISES and WTSIS

7/31/2021 Gmail - An Exploratory Examination of the Sexual Intervention Self-Efficacy of Clinical Psychology Graduate Students

 D. Elise Hutchison [REDACTED]

An Exploratory Examination of the Sexual Intervention Self-Efficacy of Clinical Psychology Graduate Students

Sandra Byers [REDACTED] Mon, Jul 26, 2021 at 3:12 AM
 To: "D. Elise Hutchison" [REDACTED]


Elise—

I am pleased for you to use these scales which you will find attached. Good luck with your research.

E. Sandra Byers, Ph.D., L. Psyc., FRSC
 Professor & Chair - Department of Psychology
 Acting Associate Dean, Faculty of Arts
 [REDACTED]

UNB campuses are open with strict adherence to New Brunswick Public Health requirements. Our priority continues to be providing high quality education while ensuring the health and safety of our community.



From: "D. Elise Hutchison" [REDACTED]
Date: Sunday, July 25, 2021 at 6:11 PM
To: Sandra Byers [REDACTED]
Subject: An Exploratory Examination of the Sexual Intervention Self-Efficacy of Clinical Psychology Graduate Students

 External message: Use caution.

<https://mail.google.com/mail/u/0?ik=8701fee8eb&view=pt&search=all&permmsgid=msg-F%3A1706341780039987767&simpl=msg-F%3A1706341780039987767> 1/2 7/31/2021 Gmail - An Exploratory Examination of the Sexual Intervention Self-Efficacy of Clinical Psychology Graduate Students

[Quoted text hidden]

2 attachments

-  **Sexual Intervention Self-Efficacy Scale with Scoring Instructions.docx**
21K
-  **Willingness to Treat Sexual Issues Questionnaire.docx**
14K

Appendix D: Permission for use of the SCS



D. Elise Hutchison [REDACTED]

Obtaining your Questionnaires from your previous research

5 messages

D. Elise Hutchison [REDACTED]

Sun, Jun 13, 2021 at 1:28 PM

To: [REDACTED]


Good Afternoon Dr. Harris,

I am reaching out as a doctoral student at Walden University currently working on my dissertation, which will heavily cite your 2008 work on clinician willingness and comfort working with client sexual concerns. I was hoping that you might be willing to provide me with the questionnaires you developed and used in the attached study of yours as well as a letter of permission to use them in my dissertation. If available I would love to have all of the questionnaires but the ones of most importance to my work would be your 1) Sexual Comfort Scale, 2) Sexuality discussions with clients scale and 3) Sexuality education and supervision scale. Thank you for your consideration of this as limited growth in this area of research has occurred since your study. Warmly,

D. Elise Hutchison, MS LMHC

D. Elise Hutchison, MHP, CMHS, LMHC, Ph.D. Candidate
Clinical Supervisor
Mental Health Clinician
SAFeT Clinical Program



 FAMILY THERAPIST COMFORT WITH AND WILLINGNESS TO WORK WITH SEXUAL ISSUES.pdf
161K

Steven Harris [REDACTED]

Tue, Jun 15, 2021 at 7:49 AM

To: "D. Elise Hutchison" [REDACTED]

Thanks for reaching out. I've attached documents to this post that should contain the information you need. You might consider looking up the original dissertation at Texas Tech University if you need additional information. Best of luck with your research. You have my permission to use all of the questions we used.
Steve

Appendix E: Permission for use of the DSI-R

DSI-R use and Permission

3 messages

D. Elise Hutchison [REDACTED]

Sun, Jul 24, 2022, at 5:19 PM

To: [REDACTED]

Good evening Dr. Skowron,

I am reaching out as a doctoral student at Walden University currently working on my dissertation proposal, which heavily cites your 1998 and 2003 articles on the creation and validation of DSI and DSI-R as well as the overall subscales. I was hoping that you might be willing to provide me with a letter of permission to use the DSI-R (the DSI with the subscale that you revised). I will also be obtaining a separate letter of permission from the American Psychiatric Association which holds the original copyright for the DSI. Thank you for your consideration. It is greatly appreciated.

Warmly,

D. Elise Hutchison, MS, MHP, CMHS, LMHC, LPC

Clinical Lead Behavioral Health Provider
[REDACTED]

D. Elise Hutchison [REDACTED]

Sun, Sep 25, 2022, at 5:30 PM

To: [REDACTED]

Hello Again Dr., Skowron,
I am just reaching out again to follow up on my previous correspondence requesting your permission to use your previously published DSI-R measure of Differentiation of Self in my dissertation study (see above the previous email). I had reached out to you during the summer and I had not heard back from you and figured I would try to reach you again now that the semester is back in progress. please let me know if I can answer any questions or concerns for you. Thanks for your consideration

Warmly,

D. Elise Hutchison, MS, MHP, CMHS, LMHC, LPC

Clinical Lead Behavioral Health Provider
[REDACTED]

Elizabeth Skowron [REDACTED]
To: "D. Elise Hutchison" [REDACTED]

Tue, Sep 27, 2022, at 9:15 AM

Dear Elise,

You're welcome to use the DSI-R in your research.

Sincerely,

Elizabeth

Elizabeth Skowron, Ph.D.

Professor, Department of Psychology

University of Oregon