

TRENDS IN DISCUSSING SEXUALITY AMONG PSYCHOTHERAPISTS IN  
TÜRKİYE: AN EXPLORATORY STUDY

A THESIS SUBMITTED TO  
THE INSTITUTE OF GRADUATE PROGRAMS  
OF  
İSTANBUL BİLGİ UNIVERSITY

BETÜL BUZLUK

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS  
FOR  
THE DEGREE OF MASTER OF ARTS  
IN  
CLINICAL PSYCHOLOGY

2025

**TRENDS IN DISCUSSING SEXUALITY AMONG PSYCHOTHERAPISTS IN  
TÜRKİYE: AN EXPLORATORY STUDY**

Betül Buzluk  
122627007

Assist. Prof. Dr. Taner Yılmaz  
İstanbul Bilgi University

---

Assoc. Prof. Dr. Alev Çavdar  
İstanbul Bilgi University

---

Assist. Prof. Dr. Rümeyşa Taşdelen  
İstanbul Galata University

---

Date of Approval: 6/20/2025

I hereby declare that all information in this document has been obtained and presented in accordance with academic rules and ethical conduct. I also declare that, as required by these rules and conduct, I have fully cited and referenced all material and results that are not original to this work.

**Name Surname:** Betül Buzluk

**Signature:**

## ABSTRACT

This study examined the factors influencing psychotherapists' engagement in sexuality-related discussions with clients in Türkiye, addressing a significant gap in the local literature. A sample of 201 therapists, whose professional experience ranged from 1 to 25 years, completed a survey measuring demographic variables, clinical training experiences, therapist characteristics, and a newly developed Perceived Comfort and Competence Discussing Sexuality Scale (PCCDSS). The PCCDSS makes a valuable contribution to the field by offering a promising tool with preliminary evidence of validity and reliability. Multiple regression analyses revealed that therapists' perceived comfort and competence, years in the profession, and sexuality-related education and supervision experiences were significant predictors of their frequency of discussing sexuality with clients. Interestingly, sexual orientation also emerged as a meaningful contributor, suggesting that queer-identified therapists discuss sexuality more than their heterosexual counterparts. Moreover, findings indicated an indirect association between therapists' sexual attitudes and their professional behavior, mediated through perceived comfort. Overall, the results successfully reflect existing trends described in prior international literature. The results also highlight the need to integrate sexuality more thoroughly into psychotherapy training in Türkiye, suggesting that enhanced educational opportunities and supportive environments may foster therapists' readiness to address this essential dimension of human well-being in clinical practice.

Keywords: Psychotherapy; Sexuality; Clinical Training; Therapist Comfort; Türkiye

## ÖZ

Bu çalışma, psikoterapistlerin danışanlarıyla cinsellik temalı konuları ele alma eğilimlerini ve bunu etkileyen faktörleri inceleyerek, Türkiye bağlamında alandaki önemli bir boşluğu doldurmayı amaçlamıştır. Mesleki deneyimleri 1 ile 25 yıl arasında değişen 201 terapistten oluşan bir örneklem, demografik değişkenleri, klinik eğitim deneyimlerini, terapistlerin bireysel özelliklerini ve yeni geliştirilen Cinselliği Konuşmada Algılanan Rahatlık ve Yeterlik Ölçeği'ni (PCCDSS) içeren bir anketi tamamlamıştır. PCCDSS, geçerlilik ve güvenilirliğine dair güçlü ön bulgularla alana değerli bir katkı sağlamaktadır. Çoklu regresyon analizleri sonucunda terapi süreçlerinde cinselliği ele alma sıklığının anlamlı yordayıcıları; terapistlerin cinsellik konuşmaya dair algıladıkları yeterlik ve rahatlık düzeyleri, meslekteki deneyim yılları ve cinsellik üzerine aldıkları eğitim ve süpervizyon olarak ortaya çıkmıştır. İlginç şekilde, terapistin cinsel yönelimi de anlamlı bir değişken olarak öne çıkmış ve queer kimliğe sahip terapistlerin heteroseksüel meslektaşlarına göre cinselliği daha fazla tartıştıkları görülmüştür. Bulgular ayrıca, terapistlerin kişisel cinsellik tutumları ile mesleki davranışları arasında, algılanan rahatlık üzerinden dolaylı bir ilişki olabileceğine işaret etmektedir. Genel olarak sonuçlar, uluslararası literatürde raporlanan eğilimlerle uyumluluk göstermektedir. Ayrıca, Türkiye'de psikoterapi eğitimine cinselliğin daha bütüncül biçimde entegre edilmesi gerektiğini vurgulamakta ve bunun, terapistlerin insan iyilik hali açısından temel bir boyut olan cinselliği ele alma yeterliliklerini geliştirebileceğini öngörmektedir.

**Anahtar Kelimeler:** Psikoterapi; Cinsellik; Klinik Eğitim; Terapist Konforu; Türkiye

To B., for they were my quiet, and my softest mirror.

## ACKNOWLEDGMENTS

This thesis would not have been possible without the guidance, support, and inspiration of several extraordinary people.

I am deeply grateful to my thesis advisor, Taner Yılmaz, whose calm and respectful presence created a space where I could feel safe, curious, and capable. His trust in me allowed me to take risks and embrace the uncertainty that comes with exploratory research.

I would also like to thank Alev Çavdar, a valued member of my jury, for her open and courageous stance toward what is deemed “unspeakable,” “shameful,” or “taboo,” which nurtured my curiosity and playfulness as a clinician and planted the earliest seeds of this research.

I am sincerely grateful to each member of the Clinical Psychology Program for fostering a rare kind of academic environment that embraced play, praised curiosity, and honored multiplicity. This unique atmosphere profoundly shaped my development as a therapist and made it possible for this thesis to take shape.

I also want to thank my dear friends—and now colleagues—Sesil, Özge, Ceren, and Damla. Walking this path of becoming a therapist alongside each of you has been a joy and a privilege. Your friendship, openness, compassion, and sincerity made these years not only bearable but beautiful. I would also like to extend my heartfelt thanks to Seda for managing to brighten my mood, even on the most exhausting days. No words feel enough to thank my dearest partner Baran. This past year, he held my worries with such tenderness, every single day.

Finally, I would like to thank my beloved family. Through my whole education, I felt the unconditional support of my father and the tireless devotion of my mother. Your belief in me has been the quiet force behind every risk I dared to take. It gave me the courage to become something in this world, to speak up when it mattered, and to trust in my own voice.

Additionally, I would also like to thank TÜBİTAK Scientist Support Programs Directorate (BİDEB) for financing my studies via the 2210-A Domestic Graduate Scholarship Program.

## TABLE OF CONTENTS

ABSTRACT .....	iv
ÖZ .....	v
ACKNOWLEDGMENTS.....	vii
TABLE OF CONTENTS.....	ix
LIST OF TABLES.....	xii
1. INTRODUCTION .....	1
2. LITERATURE REVIEW.....	5
2.1. Sexuality and Its Role in The Human Psyche .....	5
2.1.1. Sexuality.....	5
2.1.2. The Role of Sexuality in The Human Psyche .....	8
2.2. (Not) Addressing Sexuality in Mental Health Care.....	14
2.2.1. Psychotherapy.....	14
2.2.2. Other Mental Health Settings .....	17
2.2.3. Recommendations for Improvement.....	18
2.3. Therapist Willingness and Related Factors .....	20
2.3.1. Clinical Training (Education, Supervision and Clinical Experience).....	20
2.3.2. Therapist Qualities .....	23
2.4. The Context of Türkiye .....	27
2.4.1. Sexuality's Impact on Health and Well-Being in Türkiye.....	27
2.4.2. Social and Political Issues Related to Sexuality .....	28
2.4.3. Clinical and Psychological Research on Sexuality.....	29
2.4.4. Research on Sexual Dysfunctions and Disorders .....	29

2.4.5.	Studies on Professional Competencies and Attitudes Toward Sexuality .....	30
2.4.6.	Psychological Counseling, Therapy, and Educational Interventions .....	31
3.	METHODS.....	32
3.1.	Participants .....	32
3.2.	Instruments .....	34
3.2.1.	Consent Form .....	34
3.2.2.	Demographic Questions .....	35
3.2.3.	Questions on Clinical Training.....	35
3.2.4.	Questions on Sexuality Discussions .....	36
3.2.5.	The Turkish Version of the Snell-Papini Sexuality Scale.....	37
3.2.6.	Exploratory Questions (Perceived Competence and Comfort in Discussing Sexuality Scale) .....	38
3.3.	Procedure.....	40
3.4.	Data Analysis.....	42
4.	RESULTS.....	44
4.1.	A PRELIMINARY SCALE DEVELOPMENT .....	44
4.1.1.	Exploratory Factor Analysis.....	44
4.1.2.	Evaluation of Validity and Reliability of PCCDSS .....	46
4.2.	Preliminary Analysis.....	47
4.2.1.	Descriptive Statistics.....	47
4.2.2.	Normality and Linearity Assumptions .....	48
4.2.3.	Evaluation of Control Variables .....	49
4.2.4.	Correlations Between The Study Variables .....	52
4.3.	The Regression Model .....	55
4.4.	Exploratory Analysis.....	58

5.	DISCUSSION.....	60
5.1.	Perceived Competence and Comfort Discussing Sexuality Scale: PCCDSS.....	61
5.1.1.	Conceptual Basis .....	61
5.1.2.	Empirical Basis.....	62
5.2.	Factors Affecting The Frequency of Sexuality Discussions With Clients.....	62
5.2.1.	Predictors of Sexuality Discussions.....	63
5.2.2.	Non-Determinants of Sexuality Discussions.....	66
5.3.	Contributions and Implications .....	68
5.4.	Limitations and Directions For Future Research.....	73
6.	CONCLUSION.....	75
	REFERENCES .....	77
	APPENDICES	
	Appendix A. Result of the Evaluation by the Ethics Committee .....	94
	Appendix B. Consent Form.....	95
	Appendix C. Demographic Questions .....	97
	Appendix D. Clinical Training Scales (Education, Supervision, Experience).....	98
	Appendix E. Sexual Discussions Scale .....	99
	Appendix F. The Turkish Version of the Snell-Papini Sexuality Scale .....	100
	Appendix G. Exploratory Items.....	101
	Appendix H. Permission by Steven Harris for the use of Clinical Training Scales .....	102

## LIST OF TABLES

Table 3.1. Demographic Characteristics of the Participants .....	33
Table 3.2. Exploratory Items Used in the Study.....	39
Table 4.1. Exploratory Factor Loadings of the Exploratory Items .....	45
Table 4.2. Cronbach's $\alpha$ for PCCDSS .....	46
Table 4.3. Descriptive Statistics for Key Variables.....	47
Table 4.4. Comparison of Sexuality Discussions by Therapists' Sexual Orientation ....	50
Table 4.5. Post Hoc Comparisons for Different Levels of Speciality .....	51
Table 4.6. Correlations Between the Main Study Variables .....	52
Table 4.7. Correlations with Perceived Competence and Comfort .....	54
Table 4.8. Collinearity Statistics Including <i>Age</i> .....	55
Table 4.9. Collinearity Statistics Excluding <i>Age</i> .....	56
Table 4.10. Model Fit Measures .....	56
Table 4.11. Factors Predicting the Frequency of Sexuality Discussions .....	57

## INTRODUCTION

Sexuality is a fundamental and integral part of human life; shaping individual identity, social interactions and relationships. Research shows that sexual satisfaction is closely linked to overall quality of life (Diamond & Huebner, 2012). Positive sexual experiences can foster intimacy, enhance bonding, and provide pleasure while satisfying a variety of personal needs (Satcher, 2001). Moreover, sexuality can serve as an important source of support within intimate relationships, contributing to numerous health benefits that close connections can offer. Conversely, negative sexual experiences or societal stigma surrounding one's sexual expression and identity can adversely affect an individual's well-being. An individual's perception of their "sexual self" significantly influences their overall self-image and self-confidence (Harris & Hays, 2008). Given its central importance to human life, sexuality is deeply connected to both mental and physical health (Diamond & Huebner, 2012). In their review, Diamond and Huebner (2012) highlight the connections between sexuality and well-being, as well as its links to morbidity and mortality, urging researchers and clinicians to incorporate sexuality into their work. Numerous international organizations have called on mental health professionals, particularly family and couples therapists, to address sexual health as part of their practice (Dermer & Bachenberg, 2015).

Despite the profound influence of sexuality on both physical and mental health, the attention given to sexuality-related issues by mental health professionals often falls short. Research highlights the discrepancy between the importance of addressing sexual concerns in psychotherapy and the reality of how frequently these issues are actually discussed in clinical settings. For example, a survey conducted by Reissing and Gulio (2010) with clinical psychologists revealed that 60% of the respondents reported either never or infrequently addressing sexuality in psychotherapy. This lack of engagement with sexuality-related issues may unintentionally signal to the client that such topics are not suitable for discussion in psychotherapy, potentially hindering progress in addressing important aspects of their well-being (Love & Farber, 2017). Further, psychotherapists'

behaviors—such as their avoidance or discomfort in discussing sexual matters—can strongly influence how clients perceive the therapeutic process. If psychotherapists exhibit signs of unease or hesitation when sexuality issues arise, it may suggest to clients that these topics are taboo or dangerous to bring up, potentially damaging the therapeutic alliance. Such discomfort may also lead to missed opportunities for deeper, more meaningful work, as clients may feel that their sexual concerns are invalid or not welcome in psychotherapy (Love & Farber, 2017). Studies have shown that a lack of open discussion about sexuality can have negative consequences, both for the client and the therapeutic relationship (Cupit, 2010; Dermer & Bachenberg, 2015; Love & Farber, 2017, Reising & Gulio, 2010). According to Love and Farber (2017), failing to address sexual issues can result in diminished therapeutic gains and may even cause harm to the client in the long run. This underscores the importance of understanding and addressing the factors that contribute to psychotherapists' reluctance to incorporate sexuality into their practice.

Currently, there is no research conducted in Türkiye that investigates the trends surrounding psychotherapists' management of sexuality discussions with clients. This gap in the literature is particularly notable, as much of the existing research on clinical psychologists' attitudes and behaviors toward sexuality comes from Western contexts. The literature on clinical psychologists' tendencies to approach sexuality issues, their comfort in doing so, and the factors influencing their comfort is lacking. Given the lack of primary research investigating psychotherapist behaviors in this context, the study is primarily exploratory in nature. This study aims to explore the current situation regarding psychotherapists' handling of sexuality discussions with clients in Türkiye and provide a much-needed foundation for this particularly neglected area of research.

The study investigated how therapists' clinical training, personal characteristics, and demographics predict their self-reported frequency of discussing sexuality in practice. It hypothesized that greater professional exposure and more open backgrounds would be linked to more frequent discussions. Given the lack of Turkish research in this area, an exploratory scale (PCCDSS) was also developed and included to capture additional relevant dimensions.

More specifically and grounded in previous research, it was hypothesized that therapists with greater professional exposure (more experience, education, supervision, and relevant clinical cases) would engage in such discussions more frequently. Likewise, therapists with more open cultural or family backgrounds and more positive sexual attitudes were expected to report higher discussion frequencies. Control variables included age, gender, sexual orientation, and professional specialization. The scores of PCCDSS was also analyzed as a predictor. Although this exploratory element was not tied to specific hypotheses, it offered valuable insight into potentially relevant constructs in line with existing literature from, mostly, European and American contexts.



## **LITERATURE REVIEW**

The first section will discuss the importance of sexuality in the human psyche and its various effects on it. The following section will address the role of discussing sexuality in psychotherapy, therapists' willingness to engage with this topic, and the factors that influence this willingness. The final section will provide a review of the related literature in Türkiye.

### **2.1. Sexuality and Its Role in The Human Psyche**

#### **2.1.1. Sexuality**

Sexuality is a central and fundamental part of human existence and experience. In this study, the term "sexuality" refers to sexual experiences; sexual behavior and relationships; sex and gender identity; sexual attraction and orientation; sexual development; sexual disorders and problems; contraception and reproduction; and sexual assault. When sexuality is considered as such an umbrella term, its influential and complex role in human life and identity may be better assigned. Despite the central importance of sexuality, sex and sexuality have only been scientifically investigated for approximately 125 years (Robinson, 1973).

Between 1890 and 1910, the movement known as "sexual modernism" began to produce significant scientific works. In contrast to the Victorian thought of the time, modernist thinkers argued that sexual experiences were not inherently harmful to moral character or a depletion of vital energy (Robinson, 1973). Instead, they viewed sexuality as a valuable aspect of human life. They believed that understanding and managing sexual behavior appropriately was crucial not only for individual well-being but also for the health of society as a whole (Robinson, 1973). This perspective represented a shift from the previously dominant Victorian views of the time.

The case studies of English physician Henry Havelock Ellis and Austrian neurologist Sigmund Freud were cornerstones of sexual modernism, which can be considered as the beginning of the literature on sexuality (Robinson, 1973). Henry Havelock Ellis conducted pioneering research on a variety of sexual topics, including arousal and masturbation (Ellis, 1910); and homosexuality and transsexual identities (Ellis, 1915). His work, published between 1897 and 1923 in the seven-volume series *Studies in the Psychology of Sex*, made significant contributions to the understanding of sexuality. Meanwhile, the Austrian neurologist Sigmund Freud used case studies to establish the link between sexuality and healthy human development, introducing the idea that sexuality is present throughout the human lifespan, including in childhood (Freud, 1905). Freud's work on psychosexual development led to his theory that individuals progress through five distinct stages: oral, anal, phallic, latent, and genital (Freud, 1923). He suggested that experiences in each of these stages could shape psychological health. When development in these stages was hindered or dysfunctional, it could result in various psychological issues (Freud, 1923). Freud's work paved the way for modern psychotherapy, while Ellis is often regarded as the father of sexology due to his pioneering contributions to the field.

After the early works of sexual modernists, the scientific production of the last century changed the way sexuality is understood. For instance, it is now recognized that sexual activities can serve various purposes, not just for reproduction, and that these purposes can vary greatly between individuals and contexts. In their factor analysis study, Meston and Buss (2007) identified 13 fundamental reasons why people engage in sexual intercourse. These reasons include stress reduction, pleasure, physical desirability, experience seeking, receiving resources, gaining social status, revenge, utilitarian aims, love, commitment, emotional expression, self-esteem boost, duty or pressure, and mate guarding. In other words, people engage in sexual activity to fulfill many different physical, emotional, or material needs. Individual differences in reasons for having sex are strongly linked to differences in personality traits (Meston & Buss, 2007). Sexual behaviors and sexual interaction patterns provide important clues about a person's relationship dynamics and overall personality (Allen & Walter, 2018).

An important branch of sexuality literature is gender and sex studies. Gender and sex are crucial parts of identity. The development of sex role stereotypes can be observed as early as age 2 (Kuhn et al., 1978; Thompson, 1975; Weinraub et al., 1984). Gender labeling, gender identity, sex-typed toy preferences, and awareness of adult sex role differences are seen in 26-month-old infants more than would be expected by chance (Weinraub et al., 1984). By the age of 36 months, verbal and nonverbal gender identity, verbal and nonverbal gender labeling, and awareness of adult sex role differences are observed in the majority of children (Weinraub et al., 1984). The developments in gender studies have contributed to the understanding of how sexuality is not merely a matter of the body, but also shaped by societal norms and cultural contexts. The exploration of gender identity and the dynamics of sexual roles remains fundamental in studying the complexity of the human psyche and relationships.

Sexual attraction and sexual orientation have long been two influential topics of discussion and scientific investigation. The question of how humans choose their mates has impacted many different fields of research as well as political debates. Sexual selection plays a crucial role in Darwin's theory of evolution and is a key area of focus in evolutionary psychology (Andersson & Iwasa, 1996). The main issue in Darwin's theory of natural selection, which explains evolution, was the fact that many male animals evolve conspicuous traits that reduce their chances at survival (Darwin, 1872). Darwin's central explanation at this point was the identification of another crucial factor in evolution, aside from survival, namely the competition for mates—a driving force behind evolutionary change (Darwin, 1872). In this light, the study of sexual selection provides profound insights into how sexual behaviors and preferences drive evolutionary change across species. Sexual orientation, on the other hand, has not only become a topic of scientific interest but also a subject of political debate. Unlike gender identity, sexual orientation can be defined as the sexual or romantic attraction one feels, for example, toward people of a particular gender (Collins, n.d., "Sexual orientation"). The causes behind sexual orientation, or more specifically, the factors that determine non-heterosexual orientations, have been a topic of popular interest. Throughout history and across different cultures, the most prevalent controversy regarding sexual orientation has centered on the degree to

which sexuality is influenced by social factors and, more specifically, whether homosexuality spreads through contagion and societal acceptance (Bailey et al., 2016). The literature provides no substantial evidence that either of these factors significantly affects sexual orientation itself; however, societal acceptance and the presence of non-heterosexual representations may facilitate individuals' behavioral and verbal expression of their sexual orientation (Bailey et al., 2016). This brings attention to the ongoing discussions about the broader societal context in which sexual orientation is both expressed and understood. According to the database of the International Lesbian and Gay Association, currently 60 countries legally proscribe consensual same-sex sexual acts (Botha, 2023). Among these 60 countries, 11 impose the potential death penalty for homosexuality (Botha, 2023). Sexual attraction, mate choosing, and sexual orientation are all influential topics of discussion and scientific inquiry. They also serve as key examples of how sexuality may intersect with politics, legal frameworks and lawmaking.

As such, sexuality is not only solely a personal or a psychological construct but also an intricate social and political issue that shapes both individual identities and broader societal structures. This intersection of personal, societal, and political dimensions underscores the complexity and importance of sexuality on both a personal and societal level.

### **2.1.2. The Role of Sexuality in The Human Psyche**

It has been noted that sexuality holds an undeniable position of relevance in various fields such as psychology, sociology, politics, law and history. This section will focus on the impact of sexuality on human psychology and health. While the complex and multifaceted nature of sexuality allows for a wide range of effects on individuals, for the sake of relevance to the present study, the influence of sexuality will be specifically addressed through the lenses of relationships, self and identity, and mental and physical health.

### **2.1.2.1. Relationships**

Romantic relationships are believed to consist of three core behavioral systems: caregiving, attachment, and sexuality (Shaver et al., 1987). Attachment and sexuality are two distinct systems in the sense that their behavioral manifestations may occur separately, and these two systems fulfill different evolutionary purposes (Birnbaum, 2010). Nevertheless, attachment and sexuality inevitably intersect, as long-term romantic partners often serve as both attachment figures and sexual partners (Birnbaum, 2010; Impett et al., 2014). Hence, attachment and sexuality are interconnected systems, in which changes in one are expected to cause changes in the other. For example, attachment avoidance has been found to be associated with the suppression of harmful relational consequences of negative sexual interactions, while also suppressing the positive relational benefits of sex (Birnbaum et al., 2006). On the other hand, attachment anxiety is correlated with a rather conflicted interpretation of sexual experiences, which intensifies the impact of both positive and negative sexual experiences on relationship dynamics (Birnbaum et al., 2006). Highly anxious individuals may often turn to sex to fulfill their need for reassurance, and while doing so, they tend to be excessively focused on their partner's sexual needs (Davis et al., 2004). Although anxiously attached individuals may experience a stronger sexual drive and a stronger tendency to sustain passion over time, their satisfaction with both their sexual and marital life is reported to be lower than that of the general population (Davis et al., 2004).

The interplay between attachment and sexuality suggests that the quality, as well as the frequency, of sexual interactions between partners may help counterbalance the negative effects of attachment-related issues (Little et al., 2010). In a study using participants' daily reports, the results indicated that individuals with an anxious attachment style did not experience lower marital satisfaction on days they had more fulfilling sex (Little et al., 2010). Furthermore, in couples with higher sexual frequency, avoidant attachment did not appear to negatively impact marital satisfaction.

Sexuality constitutes one of the fundamental components of romantic relationships, making its influence on relationship dynamics inevitable. Research involving both

married and dating couples has demonstrated that sexual satisfaction is associated with relationship satisfaction in both groups (Byers, 2005; Henderson-King & Veroff, 1994; Edwards & Booth, 1994). A longitudinal study comparing sexuality with various well-being indicators among middle-aged married individuals (Edwards & Booth, 1994) revealed a close association between these two variables. As an individual's sexual happiness increases, both relationship satisfaction and overall well-being also improve (Edwards & Booth, 1994). Additionally, not only current sexual satisfaction, but also one's own earlier sexual satisfaction, has been found to predict subsequent relationship satisfaction (Fallis et al., 2016).

In addition to married couples, sexual satisfaction also plays a crucial role in the relationships and personal well-being of individuals in dating relationships. For dating men and women, sexual satisfaction is correlated with relationship satisfaction (Sprecher, 2002). A similar relationship holds for other relationship quality indicators, such as love and commitment (Sprecher, 2002). The connection between sexual satisfaction and these relationship variables suggests that sexuality influences how partners feel about each other and their level of commitment to the relationship.

Furthermore, satisfying sexual experiences can contribute to the sustainability of a relationship. Sexual satisfaction levels during the first year of marriage have been shown to predict the continuation of the relationship in later years. Edwards and Booth's (1994) longitudinal study indicated that a decline in sexual satisfaction within the first three years can predict divorce rates over the subsequent five years. While numerous studies have supported the association between sexuality, relationship quality, and relationship longevity, determining the directionality of this relationship remains complex. Longitudinal data suggests that both relationship and sexual satisfaction evolve over time, but it would be inappropriate to assert a unidirectional cause-and-effect relationship (Quinn-Nilas, 2020). The relationship between these two variables is dynamic and interconnected; for example, high sexual satisfaction in the early stages of a relationship can protect against declines in relationship satisfaction (Quinn-Nilas, 2020). The reciprocal nature of the relationship between partners' feelings of love, commitment, and

sexuality makes answering the question of causality appear futile (Henderson-King & Veroff, 1994).

#### **2.1.2.2. Self and Identity**

The notion of sexual self-concept, which refers to how individuals perceive themselves as sexual beings (Deutsch et al., 2014), is crucial in understanding the relationship between sexuality and selfhood. The development of sexual self-concept is influenced by a wide range of factors, including biological elements such as age, sex, and disability, psychological factors such as body image and a history of sexual abuse, as well as social influences such as parenting and media exposure (Potki et al., 2017).

Sexual self-concept plays a pivotal role in the formation of one's identity. It is well established that sexuality-related factors hold considerable significance during the process of identity formation, particularly during adolescence (Temple-Smith et al., 2015). In this developmental phase, young individuals negotiate and establish these aspects of their identity within the social dynamics present in educational settings (Gonick & Conrads, 2022). Consequently, the way in which individuals perceive and experience their gender and sexuality, particularly during adolescence, has profound implications for their overall sense of self. For instance, there are notable differences in how girls and boys experience the impact of puberty. It has been observed that puberty and sexual development have a significantly more detrimental effect on the self-esteem of adolescent girls than on boys (Martin, 1996). Moreover, dominant cultural norms impose particular standards of appearance and behavior upon women, which can shape their sense of identity and body image (Leavy & Hastings, 2010). The emotional experience of bodily changes, perceived sexual expectations, and sexual encounters is of particular importance (Martin, 1996).

In a similar vein, heterosexism within societies has been shown to adversely affect the personality development and behavioral patterns of LGBTI+ individuals (Collins & Levitt, 2021). Sexual self-concept and sexual behavior patterns interact and evolve in tandem (Hensel et al., 2011). While factors influencing the "outness" of queer men, such

as experiences of discrimination, are largely shaped by social dynamics (White & Stephenson, 2014), having a more established and openly acknowledged identity as a homosexual or bisexual man is associated with a reduced likelihood of engaging in sexual risk-taking behaviors (White & Stephenson, 2014). Furthermore, homosexual individuals may experience more frequent deviations in their self-concept compared to heterosexual individuals, driven by societal expectations and norms (Larson, 1981). A negative or inconsistent self-concept can pose significant risks to an individual's well-being and mental health. For instance, sexual self-concept ambiguity has been shown to increase suicide risk among sexual minority women (Talley et al., 2016). Moreover, sexual minority individuals, both men and women, generally exhibit lower self-esteem compared to their heterosexual counterparts (Bridge et al., 2019).

Sexual self-concept is reciprocally related to self-esteem and self-compassion. Higher levels of self-compassion are associated with higher sexual esteem (Nabila & Larue, 2023) and greater sexual satisfaction (Loveless & Quinn-Nilas, 2024). Just as a negative sexual self-concept can be detrimental to individuals, a positive sexual self-concept may be protective. To illustrate, a positive sexual self-concept is strongly correlated with a favorable experience during pregnancy (Lund, 2019). Further, in postmenopausal women, possessing a positive sexual self-concept is significantly inversely correlated with stress, anxiety, and depression levels (Heidari et al., 2017). Moreover, self-esteem is found to be positively correlated with sexual health. Individuals with higher self-esteem tend to exhibit better sexual health outcomes (Sakaluk et al., 2020). Likewise, just as self-esteem can improve sexuality, positive sexuality can also enhance self-esteem. For example, the development of sexual communication skills has been found to contribute to a higher self-esteem (Seidler et al., 2016). Furthermore, acceptance of one's sexuality is both associated with and crucial for the development of a positive self-esteem (Helminiak, 1989).

### **2.1.2.3. Mental and Physical Health**

Sexuality is intricately connected to a range of health conditions, encompassing both physical and mental aspects. The literature is extensive regarding, on one hand, the protective effects associated with maintaining a satisfactory sexual life, and, on the other hand, the unfavorable consequences of untreated sexual issues on overall health. Consistent evidence supports the notion that poor overall health is linked to diminished sexual activity (Bahnsen et al., 2022; Dekker et al., 2020), as well as higher rates of sexual dysfunction (Bahnsen et al., 2022; Christensen et al., 2011a). Moreover, research indicates that sexual satisfaction exerts a significantly positive effect on well-being by enhancing the capacity to cope with stress and reducing anxiety (Yıldırım & Yentür, 2024). Especially within the LGBTQI+ community, sexual satisfaction is found to be associated with lower levels of depression and anxiety (Biss & Horne, 2005). Notably and in women, the frequency of vaginal intercourse has been linked to a reduction in alexithymia, which in turn contributes to greater emotional awareness and corresponding psychological benefits (Brody, 2003). A higher frequency of penile-vaginal intercourse in women is also associated with an increased resting heart rate variability, which is a recognized marker for cardiovascular health outcomes (Brody & Preut, 2003).

Sexuality is a fundamental aspect of life across all stages of development. While early sexual behaviors may have negative repercussions, in late adolescence, sexuality is generally regarded as a positive experience (Vasilenko et al., 2014). In adolescent women, a healthy sexual life is correlated with reduced substance abuse, lower levels of depression, improved social integration, and enhanced self-esteem (Hensel et al., 2016). Among college students, greater sexual activity is linked to improved short-term well-being (Vasilenko & Lefkowitz, 2018). Regarding the elderly population, sexual inactivity has been shown to have significant associations with cardiovascular health, as well as with conditions such as cancer, hearing loss, dementia, dermatological, musculoskeletal, and gastrointestinal disorders, in addition to mental health challenges (Bach et al., 2013).

Given the broad influence of sexuality on health, it is unsurprising that it is also associated with mortality (Diamond & Huebner, 2012; Smith, 1997). A large-scale study of male

participants with a 10-year follow-up (Smith, 1997) demonstrated that orgasm frequency is a significant predictor of mortality risk. Specifically, the mortality risk was nearly 50% lower in the high-frequency orgasm group compared to the low-frequency group. Just as an active sexual life may serve as a protective factor for men, sexual dysfunctions may be indicative of underlying health issues. Sexual dysfunction, particularly erectile dysfunction, has been linked to cardiovascular disease, diabetes, neurological disorders, and can act as an early indicator of ischemic heart disease (Bahnsen et al., 2022; Kliesch, 2020). However and to give an example, in a German cohort, only one in five men seeks medical assistance for sexual dysfunction (Kliesch, 2020). Although poor health is similarly associated with higher rates of sexual dysfunction in both men and women, the relationship between sexuality and health appears to be stronger for physical health concerns in men and for mental health issues in women (Christensen et al., 2011b).

Despite the critical importance of sexual health, the study of sexuality remains underappreciated within the field of health psychology (Diamond & Huebner, 2012) and is frequently neglected or stigmatized by mental health professionals (Montejo, 2019). The promotion of sexual well-being, coupled with an emphasis on the detrimental effects of sexual myths and cultural stigmas surrounding sex, gender, and sexual orientation may perform wonders on health at both a personal and societal level (Rao et al., 2011).

## **2.2. (Not) Addressing Sexuality in Mental Health Care**

### **2.2.1. Psychotherapy**

Sexual difficulties are common, especially in psychiatric patients and individuals with mental health issues (D'arrigo, 2021). Moreover, both mental health problems and psychotropic medications can alter an individual's desire and/or ability to engage in sexual activities (Quinn et al., 2011). Although sexuality is integral to various aspects of mental health and sexual problems are frequently encountered, extending beyond sexual dysfunctions, sexuality is often a neglected area of inquiry in mental health settings (Timm, 2009).

In the context of psychotherapy, neglecting to address sexuality can result in ruptures and diminished therapeutic gains (Love & Farber, 2017). Firstly, avoidance of discussions about sexuality may signal to the client that sexuality is a taboo (Timm, 2009) or inappropriate to discuss in therapy, which, in turn, may lead the client to avoid discussions about sexuality altogether in an effort to prevent potential harm to the therapeutic relationship (Love & Farber, 2017). Secondly, neglecting discussions of sexuality might cause clients to assume that sexuality is irrelevant to psychological well-being. Since sexuality is not irrelevant but rather an important aspect of an individual's life, ignoring this topic would also mean overlooking valuable clinical information (Timm, 2009). Furthermore and in addition to creating emotional distance between the therapist and client (Love & Farber, 2017), neglecting discussions about sexuality can generate considerable emotional distress for clients, especially when sexuality is a core issue for them (Manickam, 2019). On the other hand, therapists' normalization of sexual topics during therapy, as well as their demonstration of curiosity and empathy, might foster a deeper connection between the therapist and the client (Love & Farber, 2017). A deeper connection and a safer environment, in turn, can enhance therapeutic gains for the client.

Based on the existing literature, one of the main reasons why therapists report feeling uncomfortable discussing sexuality with their clients is their lack of professional sexuality education (McClure, 2012) and insufficient clinical training in sexuality-related issues (Timm, 2009). Research shows that even though a psychotherapist may possess a good amount of knowledge on human sexuality; the mere education they had without also gaining psychological theoretical background, without spending a dedicated time to reflect on personal issues and biases and without the opportunity for supervision, may lack meaningful impact. Contrary to their hypotheses, both Harris and Hays (2008) and Cupit (2010) found that knowledge about sexual health was not a significant predictor of the frequency with which psychotherapists brought up sexual topics in their sessions. Regarding the topic of sexuality, each therapist is likely to have their own personal responses, biases, and vulnerabilities, which ought to be discussed and evaluated as part of the training itself (Ridley, 2006). A lack of knowledge may not be as harmful as negligence, as clients tend to appreciate when their therapist acknowledges their

limitations in understanding specific issues with a motivation to learn more (Simpson & McDowell, 2019; Love & Farber, 2017).

Another reason some therapists may leave sexuality unaddressed is related to cultural and social taboos surrounding this topic. Societal taboos about sexuality (Manickam, 2019; McClure, 2012) and therapists' personal values regarding this subject (Ford & Hendrick, 2003) contribute to the alarming level of avoidance of much-needed conversations about sexuality in mental health settings. Moreover, there are historical views and tendencies to think of individuals with mental health issues as asexual or genderless, with no connection to sexual activities or other aspects of sexuality, such as gender (McClure, 2012). These misconceptions may position sexuality as a "peripheral issue" in the mental health care profession. In fact, a qualitative analysis conducted with a group of mental health nurses, psychologists, and psychiatrists (Urry et al., 2019) revealed that most participants justified their silence on the issue of sexuality with the belief that sexuality was an unimportant issue that rarely comes up in therapy and is not beneficial to discuss (Urry et al., 2019). Furthermore, most mental health nurses report that they do not consider sexuality a priority for individuals with mental illness or that they feel discussing sexuality with patients is not part of their responsibilities (Quinn et al., 2011).

Clients' perspectives on (not) discussing sexuality may differ from those of mental health professionals. First, the literature indicates that most clients expect and prefer their therapist or other mental health service providers (Zhang et al., 2020) to initiate the conversation. For example, in psychotherapy, if not directly asked; clients may tend to avoid addressing sexuality due to shame, fear of judgment, and a fear of damaging the relationship they have with their therapist (Love & Farber, 2017). Especially when sexuality is a core issue for the client, the therapist's handling of the topic might become even more significant. For example, sexual minority clients report that they expect their therapists to understand their sexual identity and address it directly within the context of psychotherapy (Quiñones et al., 2017). Thus, to create a space for open dialogue, it is necessary for therapists to initiate and discuss sexual topics in a nonjudgmental and welcoming manner, normalizing the conversation (Love & Farber, 2017; Urry et al., 2019). It is valuable to create a safe space for gradual disclosure as well, acknowledging

that talking about sex is both important and challenging (Love & Farber, 2017; Urry et al., 2019).

### **2.2.2. Other Mental Health Settings**

The avoidance of sexuality discussions can be observed in every mental health service, and it is not exclusive to psychotherapy. For example, it is frequently reported in the literature that, although most mental health nurses acknowledge the importance of sexuality, they remain reluctant to discuss it with their patients (Quinn et al., 2011). By promoting safe sex, discussing sexual problems, and providing basic education related to the patients' issues, mental health nurses have the opportunity to enhance their patients' overall well-being and address an essential aspect of their health that is often overlooked in clinical settings (Quinn & Browne, 2009). On the other hand, they avoid conversations about sexuality due to personal discomfort, lack of sexuality education, and institutional fear (Hendry et al., 2018). Furthermore, mental health nurses often overlook the side effects of psychotropic medications on sexual health, which can interfere with patients' sexual well-being (Higgins et al., 2005) while they could play an important role in informing patients and monitoring these side effects (Higgins et al., 2007). The negative effects of these medications on sexual health might impact multiple areas of patients' lives, most importantly their relationships and their commitment to the treatment they receive (Higgins et al., 2007).

Under the heading "Self and Identity," the critical role of adolescence in sexual development and the related impacts on psychological well-being are discussed. School counselors play an important role in providing sexuality education to the adolescent population (Behun et al., 2017), although they generally fail in this role (Milton et al., 2001). For example, in the United States, although counselors reported high support for the sexual health rights of youth, they also reported low participation in actual HIV prevention practices (Joe et al., 2023). There is a significant lack of sexuality education in the training programs that school counselors receive, and this may be one of the factors hindering their effectiveness of addressing sexuality with students (Behun et al., 2017).

In the absence of adequate training, counselors may face challenges in delivering accurate information and guidance, potentially depriving students of essential support during a critical stage of development. Relationship issues, sexual orientation, sexually transmitted diseases, and pregnancy are among the main reasons why students turn to school counselors regarding topics related to sexuality (Behun et al., 2017); which might be concerning since without adequate preparation school counselors may not be fully equipped to handle the complexity of these critical issues (Milton et al., 2001).

In rehabilitation settings, particularly for older adults, the literature suggests that occupational therapists face significant barriers in addressing the sexual health needs of their clients (McGrath & Lynch, 2014). Occupational therapists often demonstrate insufficient competence and confidence when it comes to elderly sexual health, and they possess not only a lack of resources but also a lack of prioritization (McGrath & Lynch, 2014). Furthermore, many people with disabilities report that they do not receive information or guidance regarding the sexual aspects of their rehabilitation (Northcott & Chard, 2000). In a qualitative study (Northcott & Chard, 2000) using in-depth interviews with adults with disabilities, all participants reported their need for information and guidance on the sexual aspects of rehabilitation, yet they were uncertain about who should be responsible for providing this support. Research indicates that while most occupational therapists consider addressing clients' sexual health to be within their professional scope, only a few incorporate it into their practice (Young et al., 2019).

### **2.2.3. Recommendations for Improvement**

It has been underlined that even though sexuality is deeply connected to overall mental and physical health, the significant gap in both mental and physical healthcare practices regarding sexual health persists. To develop a comprehensive approach and provide holistic care, sexuality should be recognized as an essential component of overall health that must not be overlooked (Hendry et al., 2018). The literature suggests two main ways to improve the situation: institutional change and professional development.

From an institutional perspective, a shift in attitudes towards recognizing the importance of sexual health and well-being is needed (Hendry et al., 2018; McClure, 2012). Mental health clinicians report a need for access to knowledge and support from their workplaces and peers in order to feel more enabled to incorporate sexuality into their practice (Urry et al., 2024). Increasing training options for mental health professionals and raising client comfort could be particularly valuable through an institutional-level shift (McClure, 2012). The lack of professional sexuality education for mental health professionals, as well as the absence of clear policies, can be important barriers to incorporating sexuality into mental health care (McClure, 2012).

As for individual-level challenges, it is emphasized that mental health professionals often avoid addressing sexuality in their practice and face various difficulties when attempting to do so. These challenges include a lack of education and clinicians' own discomfort with sexuality discussions (D'Arrigo, 2021). Thus, the literature suggests that increasing competency and addressing personal discomfort are necessary to better support clients (D'Arrigo, 2021; Love & Farber, 2017). Since comfort and competency are interrelated, continuous education for mental health professionals could be particularly helpful. Ongoing professional development and training, including training programs, staying updated with new research, workshops, and supervision, can enable professionals to work on and overcome their discomfort (D'Arrigo, 2021; Ridley, 2006; Love & Farber, 2017). Any therapist may have their own biases and limitations when addressing sexuality with clients, which can impact their ability to effectively focus on the needs of patients. This is why reflective practice and self-awareness are of particular importance (Ridley, 2006). Continuous development supported by training, supervision, and reflective practice may improve clinicians' confidence and comfort, which can increase their willingness to incorporate sexuality into their practice (Hendry et al., 2018; Love & Farber, 2017).

### **2.3. Therapist Willingness and Related Factors**

Despite the crucial role of sexuality in human life and its significant impact on both physical and mental health, mental health professionals often fail to adequately address sexual issues. Research indicates a discrepancy between the need to discuss sexual concerns in psychotherapy and the reality of how often these topics are actually raised in clinical practice. For example, a survey conducted by Reissing and Gulio (2010) with practicing clinical psychologists in Canada found that 60% of participants reported rarely or never addressing sexuality in therapy. Similarly, a study in Austria (Seitz et al., 2020) found that only about one-third of psychiatrists and psychotherapists discussed sexual health issues with their clients, despite recognizing the importance of the topic. Furthermore, the study showed that 25% of psychiatrists suspected sexual health issues in 60-100% of their patients but did not inquire about these concerns (Seitz et al., 2020). To address this issue effectively, researchers such as Reissing and Gulio (2010) highlight the importance of exploring the underlying factors that influence clinicians' reluctance to engage in discussions about sexuality.

#### **2.3.1. Clinical Training (Education, Supervision and Clinical Experience)**

In the late 2000s and early 2010s, several studies (Cupit, 2010; Harris & Hays, 2008; Miller & Byers, 2012; Træen & Schaller, 2013) investigated the reasons behind the low willingness of psychotherapists to address sexuality in psychotherapy. These studies consistently highlighted the importance of graduate-level education and supervision in sexuality-related issues as key factors influencing psychotherapists' comfort and willingness to engage with sexual topics in their clinical practice (Miller & Byers, 2012). Furthermore, psychotherapists' comfort has been shown to significantly impact their willingness to discuss sexuality in psychotherapy, which can also affect the frequency and quality of these discussions (Harris & Hays, 2008; Moore, 2018).

The sexuality education that clinicians and counseling psychologists receive during their practicum, internships, and graduate studies often falls short; even though the depth and

breadth of this education could become pivotal in their ability to handle sexuality discussions in therapy (Miller & Byers, 2010). The training psychologists receive regarding sexuality issues is often limited or even absent, especially concerning healthy sexuality (Miller & Byers, 2010), sexual functioning and behavior, sexual ethics, and sexual expression (Abbott et al., 2021). The literature emphasizes the need for marital, couple, and family therapists (Dermer & Bachenberg, 2015; Harris & Hays, 2008), systemic psychotherapists (Markovic, 2007), and psychotherapists in general (Hanzlik & Gaubatz, 2012; Miller & Byers, 2010) to receive training that better addresses clients' needs related to sexuality. Even if internship programs or graduate-level training include some education on sexuality, it is often limited to sexual problems and disorders (Miller & Byers, 2010) and fails to be comprehensive (Abbott et al., 2021). The main barriers to offering more thorough sexuality training include limited staff expertise, a lack of prioritization of sexuality topics, discomfort around sexuality discussions, and the belief that sexuality training falls outside the scope of internship duties (Abbott et al., 2021).

Træen and Schaller's (2013) study, which involved 2,352 psychologists, found that psychologists who were self-confident and had discussed sexuality during supervision were far more likely to address sexual concerns with their clients. In contrast, those who did not discuss sexuality in supervision tended to avoid certain sexual topics when working with clients (Træen & Schaller, 2013). These findings highlight the importance of not only personal knowledge of sexuality but also institutionalized support—namely, supervision and clinical training—in fostering an environment where sexual issues can be openly addressed. In their 2008 study, Harris and Hays further advanced this understanding by proposing that sexuality education and supervision form "the cornerstone for a therapist's base level of comfort" in dealing with sexual issues (Harris & Hays, 2008, p. 82). Their research with couple and family therapists revealed that psychotherapists who received specialized clinical training in sexuality and related issues were far more likely to engage in open discussions about sexuality with their clients (Harris & Hays, 2008).

However, there is an important distinction: the level of sexual health knowledge that psychotherapists possess does not necessarily correlate with their willingness to discuss

sexuality in psychotherapy (Cupit, 2010; Harris & Hays, 2008). Contrary to their hypotheses, both Harris and Hays (2008) and Cupit (2010) concluded that knowledge of sexual health does not significantly predict how often psychotherapists introduce sexual topics during their sessions. This suggests that a mere understanding of sexual health may not be sufficient; rather, it is the type of training psychotherapists receive—specifically, clinical education and supervision on sexuality—that influences their professional behavior regarding sexual topics in psychotherapy.

Moreover, in addition to education and supervision, previous clinical experience with sexuality-related issues may also play a role in fostering psychotherapists' willingness to engage in sexual topics. Psychotherapists with more prior clinical experience addressing sexuality issues are more likely to feel comfortable and confident in their ability to handle sexual topics in psychotherapy (Cupit, 2010; Harris & Hays, 2008).

Given the proven importance of clinical training (education, supervision, and experience) on sexuality, Miller and Byers (2012) investigated potential mediating factors in the relationship between training and psychotherapists' behavior. Their analysis revealed that higher levels of education in sexuality increased psychotherapists' likelihood of engaging in sexuality discussions by enhancing their "sexual intervention self-efficacy." This term refers to the psychotherapist's confidence in addressing sexual issues with clients (Miller & Byers, 2012). Furthermore, psychotherapists' comfort has been shown to significantly influence their willingness to discuss sexuality in psychotherapy, which can positively impact the frequency and quality of these discussions (Harris & Hays, 2008; Moore, 2018). It can be concluded that the factors most strongly linked to psychotherapists' willingness to discuss sexuality in psychotherapy are their undergraduate sexuality education, clinical practice, and supervision on sexuality issues, along with the confidence and comfort levels they have in handling these topics. Psychotherapists' confidence and comfort in addressing sexuality issues with their clients impact how frequently they bring up these topics, while clinical training and supervision enhance their confidence and comfort in doing so (Hanzlik & Gaubatz, 2012; Harris & Hays, 2008; Miller & Byers, 2012; Moore, 2018). However, simply having knowledge about sexuality does not appear to be a significant predictor.

### **2.3.2. Therapist Qualities**

Beyond clinical training, there is some evidence suggesting that the personal characteristics of clinicians may influence their behavior when discussing sexuality with clients. Clinicians' own traits, including age, gender, level of experience, and personal attitudes toward sexuality, can shape how comfortable and willing they are to engage in sexuality-related conversations during psychotherapy sessions. The literature suggests that although these variables may not significantly affect the frequency of such discussions alone, they still lead to notable differences.

#### **2.3.2.1. Therapist Characteristics and Background**

Personal characteristics such as age and experience are among the factors discussed in the literature as shaping clinicians' engagement with sexuality-related issues in therapy. Træen and Schaller (2013) reported that older psychotherapists were more likely than younger ones to initiate sexuality-related discussions. When they did, they were also more likely to address specific topics such as sexual satisfaction, positive sexual experiences, and sexual orientation (Træen & Schaller, 2013), which are among the topics that are generally considered less likely to be brought up by younger or less experienced clinicians. Cupit (2010) identified a positive relationship between years of experience and the frequency of sexuality-related discussions, suggesting that psychotherapists with more years of practice tend to be more willing to engage in such conversations.

This pattern suggests that age, which is closely associated with professional experience, may influence how clinicians approach the topic of sexuality in therapy. However, because age and experience are typically correlated, it remains difficult to isolate the effect of age alone. In general, older and more experienced clinicians tend to discuss sexuality more frequently than their younger and less experienced colleagues (Cupit, 2010; Træen & Schaller, 2013). Additionally, Træen and Schaller (2013) found that younger clinical psychologists—those with fewer years of experience—were less likely to inquire about sexual orientation, suggesting a tendency among less experienced practitioners to avoid certain sexuality-related topics.

When it comes to gender-related differences, it can be suggested it also plays a role in how clinicians engage in sexuality discussions, although no significant difference has been found between genders in terms of their overall level of engagement (Ford & Hendrick, 2003; Hanzlik & Gaubatz, 2012; Træen & Schaller, 2013).

In other words, while there is no robust evidence indicating that one gender consistently addresses sexuality more than the other, gender-based differences do exist. To illustrate, studies indicate that female therapists tend to feel more comfortable discussing issues related to sexual orientation, whereas male therapists may be more adept at addressing topics involving non-normative sexual behavior (Ford & Hendrick, 2003). Additionally, a greater proportion of male therapists report initiating conversations about positive sexual experiences, while female therapists may be more inclined to inquire about negative sexual experiences and sexual trauma (Træen & Schaller, 2013). This pattern may reflect broader societal norms around gender and sexuality, where female clinicians are more inclined to address potentially traumatic or negative experiences, while male clinicians may tend to focus on positive or normative aspects. Moreover, therapists may approach clients differently depending on the client's gender. According to research conducted with clinical PsyD trainees (Hanzlik & Gaubatz, 2012), female trainees reported significantly greater discomfort than their male counterparts when working with male clients on sexual issues.

In addition to the previously mentioned factors, researchers have also examined how more complex clinician characteristics such as religious and cultural values and early family experiences related to sexuality may influence their professional behavior. Beyond sexuality as well, psychotherapists' spiritual and religious identities have also been found to influence their overall therapeutic practice and the ways in which they relate to clients who hold similar or differing beliefs (Magaldi-Dopman et al., 2011). These characteristics, primarily explored through qualitative methodologies (Berman-Brodsky, 2022; Naughton, 2022), appear to influence whether clinicians feel comfortable addressing sexuality during psychotherapy. For instance, Berman-Brodsky (2022) emphasized that experiences with how sexuality was discussed within the family during childhood may shape psychotherapists' attitudes towards sexuality discussions in

adulthood. Therapists who were raised in families where sexuality was talked about openly may feel more comfortable bringing up these topics with clients, whereas those from more conservative or restrictive backgrounds may experience greater difficulty doing so (Berman-Brodsky, 2022). Furthermore, another study examining the effectiveness of a group supervision program in sex therapy (Shafrir & Balahur, 2022) indicated that there were significant differences between religious and non-religious therapists. Therapists with different religious affiliations reported varying attitudes toward sexuality-related topics and expressed different supervision needs compared to their non-religious counterparts. Shafrir and Balahur (2022) suggest that the greater anxiety and heightened need for supervision expressed by religious therapists—particularly regarding certain topics—may be related to the way religious beliefs shape perceptions of what is considered acceptable or problematic in the context of sexual behavior and identity.

#### **2.3.2.2. Sexual Values and Attitudes**

The observed variation in therapists' approaches to discussing sexuality may, in part, stem from differences in their sexual beliefs and values, which are shaped by factors such as their age, gender, and religious, social, and political affiliations (Ford & Hendrick, 2003). For instance, therapists with varying levels of religious involvement may hold distinct values concerning casual sex, sexual orientation, or adolescent sexuality (Ford & Hendrick, 2003). Moreover, it is not only these individual factors alone, but also their intersectionality that may influence the therapeutic process (Haldeman, 2010). For example, the experiences of a Hispanic, atheist, gay male therapist are likely to differ significantly from those of a White, conservative, heterosexual male therapist.

Clinicians' own sexual values and attitudes, together with their beliefs about addressing sexuality in their clinical work, may influence how they approach sexuality-related topics in therapy. Although some conflicting findings suggest that personal sexual values may not significantly affect clinical practice (Moore, 2018), overall, clinicians' sexual values and attitudes appear to be associated with their willingness and comfort in incorporating

sexuality into psychotherapy (Cupit, 2010; Ford & Hendrick, 2003; Hanzlik & Gaubatz, 2012). For example, according to Hanzlik and Gaubatz (2012), among clinical PsyD trainees, sexual attitudes played a more significant role in shaping comfort levels during sexuality-related discussions than general clinical training or experience. Moreover, Cupit (2010) reported that certain dimensions of sexual attitudes—but not others—were modestly associated with the frequency of sexuality-related discussions in therapy. Specifically, permissiveness (casual sexuality) and communion (idealistic sexuality) were found to have a relationship with discussion frequency, while attitudes toward birth control were not.

Taken together, these findings suggest that a clinician's thoughts and feelings about sexuality, including their personal sexual self-concept, may in some way influence their clinical behavior. However, the literature also emphasizes that even when personal values impact practice, adequate training and supervision in sexuality-related topics can play a mitigating role (Ford & Hendrick, 2003).

Similarly, clinicians' general perspectives on whether sexuality should be addressed in therapy influence how often they initiate such discussions (Træen & Schaller, 2013; Urry et al., 2019). In their 2013 study, Træen and Schaller identified several recurring themes in Norwegian psychologists' experiences of discussing sexuality in therapy. Two of the most prominent were "patient initiative"—the belief that sexuality is a sensitive topic that should only be brought up by the client—and "spontaneous theme"—the belief that sexuality does not naturally arise in therapy unless triggered by specific circumstances. Their findings indicated that clinicians who did not endorse these views and instead recognized the importance of proactively addressing sexuality were more likely to engage in sexuality-related discussions with clients (Træen & Schaller, 2013).

The personal perspectives and subjective experiences of the clinician warrant careful consideration within the therapeutic setting, as neglecting the subjective dimensions of sexuality can result in negative consequences for both therapists and their clients (Ridley, 2006). In order to effectively respond to the needs of their clients, it may be helpful for

clinicians to remain aware of their own internal responses and to reflect on their personal vulnerabilities related to various aspects of sexuality (Ridley, 2006).

## **2.4. The Context of Türkiye**

### **2.4.1. Sexuality's Impact on Health and Well-Being in Türkiye**

Sexuality's influence on human behavior and beliefs (Sümer, 2015), interpersonal relationships (Doğan et al., 2013), well-being (Boyacıoğlu et al., 2023), and health (Hocaoğlu et al., 2014) is evident not only in global literature but also within studies conducted in Türkiye. The multifaceted direct and indirect effects of sexuality on individuals and society have been repeatedly emphasized both internationally and in Turkish research. For instance, higher sexual life quality in women is associated with greater happiness, improved quality of life, and better relational outcomes such as increased relationship longevity (Doğan et al., 2013). Similarly, for men, sexual activity constitutes an integral part of overall health and is linked to general quality of life (Çayan et al., 2017). Men in Türkiye with moderate to severe erectile dysfunction report significantly lower monthly sexual activity (approximately 3 times) compared to those without or with mild dysfunction (around 8 times), highlighting the necessity of addressing sexual dysfunction to improve men's overall health and quality of life (Çayan et al., 2017).

Moreover, for individuals with non-heteronormative sexual orientations or non-binary gender expressions, sexual identity can be a profound source of minority stress. Among gay men in Türkiye, proximal minority stressors such as concealment of sexual identity and internalized homonegativity significantly predict depression and anxiety, mediated by factors like shame and self-forgiveness (Ünsal & Bozo, 2023).

#### **2.4.2. Social and Political Issues Related to Sexuality**

Issues related to gender, sexual activities, sexual orientation, contraception, and childbirth represent some of the sexuality-related topics with significant policy implications. Especially in conservative contexts like Türkiye, research on sexuality may often intersect with political dynamics. According to Yılmaz & Willis (2020), similar to Hungary and Poland, Türkiye is undergoing a broader conservative shift that challenges the autonomy of sexual health policies and hinders the implementation of a rights-based approach. Moreover, the political regime in Türkiye over the past decade has drawn considerable power from its pervasive control over women's bodies and sexualities, while also promoting the traditional heterosexual family structure with children (Cindoğlu & Ünal, 2017).

The interaction between sexuality and social conditions has emerged as a relatively prominent research area in Türkiye. To illustrate, there is a considerable body of research focusing on the experiences of transgendered individuals and the process of sex reassignment surgery (Polat et al., 2005; Turan et al., 2015; Yüksel et al., 2000). In Türkiye, the majority of families of transgendered individuals attempt to change the situation through coercion and seek to conceal the individual's identity from their immediate social environment (Polat et al., 2005). Studies on sex reassignment surgery and pre-sex reassignment surgical psychotherapy (Yüksel et al., 2000; Zengin, 2014) highlight the psychological stress experienced by transgender individuals and emphasize the sensitivity of these processes.

A similar trend can be observed in research focusing on women. Research on female sexuality and gender can provide valuable insights into the societal implications of sexual identities. For instance, between 1990 and 2010 in Türkiye, suicide rates among women aged 15–24, the age group with the highest incidence of suicide, were significantly higher than those of men (Öner et al., 2015). Moreover, sex-related differences have been documented in both the reasons for and methods of suicide (Öner et al., 2015).

### **2.4.3. Clinical and Psychological Research on Sexuality**

Considering the impact of sexuality on well-being and mental health, Turkish studies generally align with global findings. They address not only the clinical and psychological consequences of sexual issues (Hocaoğlu, 2014; Özkan et al., 2015) but also highlight the shortcomings and developmental needs of professionals in fields such as medicine and psychological counseling (Çuhadaroğlu, 2016; Ünal Toprak & Turan, 2021). However, research investigating how sexuality is addressed in psychotherapy in Türkiye—how frequently and in what manner therapists engage with sexual issues, and the subsequent effects on clients—remains limited. Most available studies focus solely on sex therapy contexts. Therefore, the literature lacks insights into the broader trends, barriers, facilitators, and therapeutic outcomes associated with discussions of sexuality in Turkish psychotherapy.

In the Turkish context, there is a notable absence of studies directly aligned with the present research's focus. Nonetheless, the existing literature on sexuality remains valuable for its insights into the social and psychological effects of diverse sexual identities, expressions, and dysfunctions. The most relevant research conducted in Türkiye, in relation to the current study's context, can be grouped into three primary categories. These are studies on (1) sexual dysfunctions and disorders; (2) the handling of sexual issues within physical and mental health services, including proposed policy changes; and (3) social and political issues influenced by or organized around sexuality.

### **2.4.4. Research on Sexual Dysfunctions and Disorders**

A substantial body of research has focused on sexual dysfunctions and disorders, as well as sexual problems emerging with aging (Boyacıoğlu et al., 2023; Doğan et al., 2008) or after major medical procedures and chronic physical or mental illnesses (Akman et al., 2015; Hariri et al., 2011; Hocaoğlu et al., 2014). Understanding how physical and psychological challenges relate to sexual health and sexual quality of life has been an important point of focus within Türkiye's medical research domain (Boyacıoğlu et al., 2023; Hariri et al., 2011; Hocaoğlu et al., 2014).

The literature in Türkiye also demonstrates the bidirectional relationship between sexual problems and mental health outcomes. For example, experiencing medical conditions such as infertility is associated not only with other sexual dysfunctions but also with elevated risks for mental health issues like depression (Özkan et al., 2015). Likewise, women with serious mental illnesses may also face reproductive health concerns (Özcan et al., 2014). Additionally, mental health challenges such as bipolar disorder or substance use disorders have been linked to increased risky sexual behaviors (Hariri et al., 2011).

#### **2.4.5. Studies on Professional Competencies and Attitudes Toward Sexuality**

Beyond the interactions between sexuality and physical and mental health, research has examined the competencies and attitudes of medical practitioners (Doğan et al., 2008; Zengin, 2014) as well as trainees (Ozan et al., 2005; Ören et al., 2018; Ünal Toprak & Turan, 2021) regarding sexuality. For example, despite the continued importance of sexuality throughout the lifespan and the evidence suggesting that lower sexual dysfunction predicts better quality of life in geriatric populations (Boyacıoğlu et al., 2023), a study published in the *International Psychogeriatrics* identified low levels of awareness about later-life sexuality among Turkish medical doctors (Doğan et al., 2008).

For married women in Türkiye, sexual life quality shows important associations with happiness and overall life satisfaction (Doğan et al., 2013). Nurses and midwives can be among the most frequently consulted professionals regarding women's sexual concerns. Indeed, approximately 75% of midwifery students in Türkiye report that patients seek sexual counseling from them (Ören et al., 2018). The attitudes and behaviors of these healthcare providers might be significantly shaped by sexual health education. Greater educational exposure is associated with lower belief in sexual myths (Ünal Toprak & Turan, 2021). Moreover, attitudes toward sexual counseling predict comfort levels in providing such counseling among midwifery students (Ören et al., 2018). Therefore, participating in training and intervention programs aimed at challenging false beliefs, taboos, and prejudices about sexuality may be beneficial for professionals and trainees in the field (Ünal Toprak & Turan, 2021).

#### **2.4.6. Psychological Counseling, Therapy, and Educational Interventions**

Although comparatively fewer studies exist in psychological counseling and sexual therapy contexts, research in these areas also aims to understand professionals' approaches to sexuality and to improve inadequate knowledge, misconceptions, and avoidance tendencies. For instance, considering that sex education is not included in Türkiye's official national curriculum, a study with psychological counseling students reported significant improvements in sexual attitudes after a 13-week sex education course, including reductions in homophobic and patriarchal attitudes (Çuhadaroğlu, 2019).

Another example illustrating the consequences of insufficient attention to sexual health can be seen in the prevalence of vaginismus. The prevalence of vaginismus in Türkiye is notably higher than global rates; in fact, approximately 75% of Turkish women presenting with female sexual dysfunctions are diagnosed with vaginismus (Doğan, 2009). Moreover, among Turkish couples dealing with vaginismus, high rates of belief in sexual myths have been reported (Güneş et al., 2025). Cognitive-behavioral therapy, with its goal of challenging false beliefs, has been shown to not only significantly improve marital adjustment but also reduce symptoms of depression and anxiety among couples experiencing vaginismus (Öztürk & Arkar, 2017).

## METHODS

### 3.1. Participants

Participants in this study are psychotherapists who are graduates of clinical psychology or psychiatry, have completed their therapy training, and are currently practicing in Türkiye. An important exclusion criterion is having sex therapy as one's primary practice, as sex therapists specifically assess and work on sexuality issues.

There are 201 participants in total. To perform linear multiple regression analysis with 10 predictors (six independent variables and four control variables), GPower suggests a sample size of 172 (*Cohen's d* = 0.15; *power* = .95). Since the GPower analysis provides only an estimate, the target sample size was set at 200 to increase validity. The data collection process concluded with the 201st participant.

Convenience sampling and snowball sampling strategies were used. The advertisement was shared via the researcher's social media (e.g., Instagram) and through the networks of the Bilgi University Psychological Counseling Unit. The advertisement for the study provided information about consent, confidentiality, the voluntary nature of participation, the aim of the study, and the researcher's contact details. Through the advertisement, participants were directed to an online Google Forms survey (Appendix 2.). Since the survey required responses to every question, data from participants who did not complete all items were not recorded in the system and were therefore not included in the study.

The participants' mean age was 31.6, with a median of 31 and a standard deviation of 5.25. The youngest participant was 24 years old, and the oldest was 54 years old, resulting in a range of 30 years. In terms of gender, among the 201 participants, 177 identified as female, 23 as male, and 1 as nonbinary.

The participants' mean years in profession was 5.68, with a median of 5 and a standard deviation of 4.29, with the least experienced participant providing therapy for 1 year and the most experienced for 25 years, yielding a range of 24 years.

**Table 3.1. Demographic Characteristics of the Participants**

		<i>N</i>	%
Gender	Woman	177	88.1
	Man	23	11.4
	Nonbinary	1	0.5
Sexual Orientation	Heterosexual	177	88.1
	Queer	24	11.9
Speciality Group	Adult	134	66.7
	Child/Adolescent	9	4.5
	Adult & Child/Adolescent	21	10.4
	Adult & Couple/Family	29	14.4
	Child/Adolescent & Couple/Family	2	1.0
	Couple/Family	3	1.5
	Adult & Child/Adolescent & Couple/Family	3	1.5

Regarding sexual orientation, participants were divided into heterosexual and non-heterosexual (queer) groups. Those identifying as bisexual, gay, or holding other non-normative orientations were classified under the umbrella term “queer.” Additionally, one participant who identified as “heteroflexible” was considered part of the queer group due to the non-normative quality of their self-report. 24 out of the total of 201 participants were classified as queer.

Participants reported specializations in one or more of the following areas: adults, children/adolescents, and couples/families (see Table 3.1.). The majority had specialization in working with adults; there were 12 participants without adult specialization, 9 of whom solely specialized in child/adolescent therapy.

### **3.2. Instruments**

All scales and questions in the survey were mandatory and were presented in the following order:

#### **3.2.1. Consent Form**

At the beginning of the study, participants were provided with the Consent Form (see Appendix B.). The informed consent form explained the aim and voluntary nature of the study, provided details about confidentiality, participants’ right to withdraw at any time, and included the researcher’s contact information. Participants were informed that their data would be collected anonymously, following principles of privacy, and that no identifying information would be gathered. Participants continued with the survey only if they selected the option (provided in Turkish):

“I am participating in this study entirely voluntarily. I have understood the information provided to me and the explanations above. I agree to participate in the study and to the use of the information I provide for scientific purposes, including publication, reports, and presentations.”

Before starting the survey, participants were also asked, via a yes/no checkbox, whether their primary practice was sex therapy and whether they had completed their therapist training in addition to a degree in clinical psychology or medicine. Only those indicating relevant educational background and confirming that their primary practice was not sex therapy were allowed to proceed.

### **3.2.2. Demographic Questions**

In this section (refer to Appendix C.), participants answered demographic questions about their gender, age, sexual orientation, years of experience, and specialization (e.g., adults, couples & families). Moreover, participants rated the following statements on a 6-point Likert scale (1 = strongly disagree, 6 = strongly agree):

“I grew up in a family that was open to discussing sexuality.”

“According to my culture, it is not appropriate for a person to share topics related to their sexual life with others.”

### **3.2.3. Questions on Clinical Training**

This section (see Appendix D.) included three multiple-choice questions under the Sexuality Education and Experience category, where participants selected all applicable options. The questions assessed the extent of participants' sexuality education (Q1), sexuality supervision (Q2), and clinical experience with sexuality-related issues (Q3).

To assess participants' levels of sexuality-related training and experience, three scales developed by Harris and Hays (2008)—the Sexuality Education Scale, the Experience in Supervision Scale, and the Clinical Experience Scale—were identified as theoretically and contextually appropriate. After reviewing the literature, the original authors were contacted to request permission for the use of the scales and to obtain their full versions. The authors granted permission via email (refer to Appendix H.).

Q1 contained eight items (e.g., “I have attended a workshop(s) on sexuality”), Q2 had six items (e.g., “I have regularly discussed sexuality issues in supervision”), and Q3 included five items (e.g., “I occasionally work with clients on sexuality issues”). Seven items from Q1, all six items of Q2, and all five items of Q3 were direct translations of the Sexuality Education Scale, Experience in Supervision Scale, and Clinical Experience Scale developed by Harris & Hays (2008). One additional item — “I received training on sexuality that lasted more than four sessions” — was added to Q1 to capture non-school training experiences not covered by the original scales.

These three scales have been used to study trends in addressing sexuality issues among marriage and family therapists (Harris & Hays, 2008; Moore, 2018) and counselors (Cupit, 2010). Although no formal reliability and validity data are available for these scales, they were considered suitable by previous researchers. A higher number of selected items on each scale indicated a higher level of sexuality-related education and experience.

#### **3.2.4. Questions on Sexuality Discussions**

This segment (see Appendix E.) contained 10 items evaluating the frequency of participants’ sexuality discussions with their clients. Higher scores reflected more frequent discussions.

Scale items were rated on a 6-point Likert scale (1 = strongly disagree / never, 6 = strongly agree / always). These items aimed to assess the frequency and scope of therapists’ discussions on sexuality during therapy.

The first three items from Q1 were originally developed for this study to capture therapists’ general tendencies to discuss sexuality, regardless of topic or context. These items were included to address a gap in the original measure (Harris & Hays, 2008), which focused solely on specific subdomains of sexuality (e.g., sexual orientation, history of abuse) without assessing general engagement in sexuality-related conversations.

The fourth item (Q1d) was reverse-coded and directly adapted from the final item of the *Sexuality Discussion Scale* (Harris & Hays, 2008): “*I only assess and initiate conversations on sexuality-related issues when the client states that it is a concern.*”

The remaining six items (Q2a to Q2f) were also adapted from the same scale and focused on therapists’ frequency of initiating or assessing sexuality-related topics in therapy, including: sexual development history, sexual orientation, satisfaction with sexual life, typical sexual interaction patterns, experiences of sexual abuse, and issues related to contraception and reproduction.

The Sexuality Discussion Scale, developed by Harris & Hays (2008), was designed to measure therapists’ sexuality-related discussions with clients, as no other documented scales existed for this purpose. The scale’s Cronbach’s alpha was reported as 0.90. Although no additional reliability and validity data are available, the scale has been successfully used in subsequent research (Harris & Hays, 2008; Cupit, 2010; Moore, 2018). Because no Turkish adaptation of the original scale was available and the items were straightforward, this section was translated by the researcher, reviewed by her advisor, and adapted from the original scale. The total sum of these items’ scores was used as the dependent variable in this study.

### **3.2.5. The Turkish Version of the Snell-Papini Sexuality Scale**

The Turkish version of the Snell-Papini Sexuality Scale (see Appendix F) (Doğan et al., 2009) consists of 20 items distributed across three subscales: sexual-esteem (10 items, five of which are reverse-coded), sexual-preoccupation (5 items), and sexual-depression (5 items). Participants were asked to rate the degree to which each item applied to them using a 5-point Likert scale (1 = strongly disagree, 5 = strongly agree). The scoring ranged from -2 to +2, with higher scores indicating stronger endorsement.

Snell and Papini (1989) reported high factorial validity for the independence of the subscales, with Cronbach’s alpha values of .92 (sexual-esteem), .90 (sexual-depression), and .88 (sexual-preoccupation). The Turkish adaptation by Doğan et al. (2009) also demonstrated strong reliability, reporting a Cronbach’s alpha of 0.91 for the overall scale,

with subscale coefficients of 0.81 (sexual-esteem), 0.92 (sexual-preoccupation), and 0.91 (sexual-depression). Ten items from the original 30-item version were removed during Turkish adaptation due to low item-total correlations ( $<0.25$ ), resulting in a refined 20-item version. A high-low group analysis further confirmed the scale's validity. The total SS score was used as an independent variable in this study.

### **3.2.6. Exploratory Questions (Perceived Competence and Comfort in Discussing Sexuality Scale)**

This final section (refer to Appendix G.) contained 13 exploratory items without specific hypotheses. These questions addressed topics highlighted in prior studies.

Previous research on the topic of sexuality in therapeutic discussion has consistently examined the effects of therapist experience and attitudes alongside clinical training factors (Cupit, 2010; Graham & Smith, 1984; Harris & Hays, 2008; Miller & Byers, 2008, 2012; Reynolds et al., 2005; Shafrir et al., 2022; Træen & Schaller, 2013). This research led to the designing of various measurement instruments that assess therapists' comfort levels, their willingness to talk about sexual issues with clients, their beliefs and attitudes toward addressing sexuality in therapeutic contexts. However, no validated Turkish adaptations of such instruments currently exist. This represents a critical gap in the field, highlighting the need for a culturally appropriate and psychometrically robust tool to examine therapist-related variables that may influence sexuality discussions within Turkish clinical practice.

**Table 3.2. Exploratory Items Used in the Study**

Item Number	Statement	General Theme (in relation to discussing sexuality)
1	<i>Bir danışanın cinsellikle ilgili bir endişesi/konusu varsa, onu başka bir uzmana yönlendirmek en iyisi olur diye düşünürüm.</i>	Avoidance
2	<i>Cinsel sorunları olan danışanlarla çalışmamayı tercih ederim.</i>	Avoidance
3	<i>Terapilerde cinsellik konuşmak yararlı ve gereklidir.</i>	Attitude
4	<i>Danışanın temel problemi cinsellikle bağlantılı değilse cinsellik konuşmaya gerek yok diye düşünürüm.</i>	Attitude
5	<i>Danışanım cinsellikle ilgili konuşmaya başladığında telaşlanırım.</i>	Discomfort
6	<i>Danışanım cinsel hayatını ve yaşantılarını anlatırken rahatsız hissederim.</i>	Discomfort
7	<i>Danışanlarımla cinsel sorunları ve endişeleri üzerine çalışmakta rahat hissederim.</i>	Comfort/competence
8	<i>Cinsellikle ilgili konularda gerektiğinde danışana doğru bilgiler aktarabileceğime inanıyorum.</i>	Competence
9	<i>Seanslarımda cinsellikle ilgili konuları ele alış miktarımı yeterli buluyorum.</i>	Competence
10	<i>Terapilerde cinsellik konularını ele alacak genel yetkinliğim vardır.</i>	Competence
11	<i>Benimle aynı cinsiyette danışanlarla cinsellik konuşmak daha kolaydır.</i>	Gender-related ease

12	<i>Yaşı bana yakın danışanlarla cinsellik konuşmak daha kolaydır.</i>	Age-related ease
13	<i>Aynı cinsel yönelimde olduğum danışanlarla cinsellik konuşmak daha kolaydır.</i>	Orientation-related ease

*Note.* These items were presented in Turkish as part of the exploratory section of the survey, rated on a 6-point Likert scale (1 = kesinlikle katılmıyorum, 6 = kesinlikle katılıyorum).

To address this gap and to achieve more explanatory results, the exploratory items (see Table 3.2) were inspired by the relevant literature and thematic insights from prior studies that have examined therapists' beliefs, attitudes or comfort when addressing sexuality in clinical settings (Cupit, 2010; Graham & Smith, 1984; Harris & Hays, 2008; Miller & Byers, 2008, 2012; Reynolds et al., 2005; Shafrir et al., 2022; Træen & Schaller, 2013) aimed to reflect dimensions that were both clinically meaningful and theoretically consistent with the broader literature.

An exploratory factor analysis (EFA) was conducted on 13 items following evidence of meaningful correlations with the dependent variable (Sexuality Discussions). Sampling adequacy was acceptable and factorability was supported. Two factors emerged, yet most items (first 10) loaded strongly on a single dominant factor, interpreted as Perceived Competence and Comfort in Discussing Sexuality. Based on the factor structure and reliability statistics, the preliminary Perceived Competence and Comfort in Discussing Sexuality Scale demonstrated sound psychometric properties for assessing perceived therapeutic competence and comfort regarding sexuality-related discussions in therapy and was used as a composite score in the analyses to investigate its association with therapists' engagement in sexuality-related conversations.

### 3.3. Procedure

Upon receiving approval from the Istanbul Bilgi University Ethics Committee (see Appendix A.), the study was announced through social media platforms and professional psychotherapist mailing networks. Psychotherapists who responded to the advertisement

were directed to an online Google Forms survey. Prior to beginning the survey, participants were presented with an information form that provided a brief overview of the study, including details about anonymity, confidentiality, and the intended use of the data.

No identifying information, such as names or email addresses, was collected at any stage of the study. Participants were informed that their data would be used solely for research purposes, would not be linked to their identities, and would be stored in encrypted files on the researcher's password-protected personal computer. The data will be securely retained for five years following the completion of the research, after which it will be permanently deleted. Only the researcher and the academic advisor will have access to the data.

The informed consent form explicitly informed participants about the voluntary nature of their participation and their right to withdraw from the study at any point without penalty. It was further clarified that any data from participants who chose to withdraw or left the survey incomplete would not be included in the analysis.

As specified in both the advertisement and the information form, eligibility criteria for participation required individuals to have completed their clinical psychology or psychiatry education, hold psychotherapy training, and be currently practicing as psychotherapists in Türkiye. Individuals whose primary area of practice was sex therapy were excluded; to proceed with the survey, participants were required to confirm that they did not primarily practice sex therapy.

The researcher's and advisor's institutional affiliations and contact information were provided to all participants, ensuring they could reach out with any questions or concerns regarding the study.

Upon reviewing the information form, participants provided informed consent before proceeding to the survey. The survey consisted of a sequence of sections, starting with demographic questions, followed by items on sexuality education and experience, questions on sexuality discussions, the Turkish version of the Snell-Papini Sexuality

Scale, and additional exploratory questions on trends in discussing sexuality. All survey items were set as mandatory, and data from participants who did not complete the entire survey were not recorded or retained. The estimated time to complete the survey was approximately 10–15 minutes.

The target sample size for this study was 200 participants, and data collection was terminated upon reaching the 201st participant.

### **3.4. Data Analysis**

This study employed a non-experimental, quantitative research design. The independent variables included in this study were: psychotherapists' (1) years of experience, (2) level of sexuality education, (3) level of supervision on sexuality issues, (4) level of clinical experience with sexuality-related issues, (5) cultural and family background (whether they come from a culture where discussing sexuality is considered inappropriate and whether their families were open to discussing sexuality during upbringing), (6) sexual attitudes, as measured by sexual-esteem, sexual-depression, and sexual-preoccupation, and finally (7) their perceived competence and comfort discussing sexuality with clients. The main dependent variable was the frequency of sexuality discussions participants reported having with their clients. We also controlled for the effects of psychotherapist's age, gender, sexual orientation, and the client population they work with (as in adults, children and / or families).

Due to the forced-response format of the online survey, no missing data were present; therefore, no participant data were excluded, and all analyses were conducted on the full sample of 201 participants. The analyses were carried out using the Jamovi statistical software program.

This study has an exploratory dimension, as the survey we employed included 13 partially original items. The inclusion of these items was necessitated both by the need to enhance the exploratory power of the study and by the inadequacy of existing scales in the Turkish language. First, an exploratory factor analysis (EFA) was performed on a set of 13

exploratory items, as Principal Axis Factoring with Oblimin rotation was employed. The Kaiser-Meyer-Olkin (KMO) measure indicated meritorious sampling adequacy, and Bartlett's Test of Sphericity was significant, supporting the suitability of factor analysis. The first 10 items formed a factor and preliminary scale named PCCDSS. The composite score of PCCDSS was then used in the analysis as a potential predictor.

Descriptive statistics, including means, standard deviations, and frequency distributions, were calculated for each quantitative variable to describe the sample characteristics. The normality of the distributions was assessed using skewness, kurtosis, and visual inspection of distribution plots. Given the large sample size ( $N = 201$ ), Shapiro-Wilk tests were not employed. Overall, all variables were deemed to meet the assumptions of normality sufficiently.

The relationships between planned control variables and the dependent variable were evaluated. The independent samples t-test that was conducted for sexual orientation, and the Welch's ANOVA was applied to assess specialization group differences with respect to the dependent variable reported meaningful correlations. Therefore, both sexual orientation and adult specialization were included as control variables in the subsequent regression models.

No major violations of linearity, homoscedasticity, or the presence of extreme outliers were observed. Thus, assumptions for Spearman correlation and multiple regression analyses were considered adequately met. A correlation matrix was examined and it revealed numerous meaningful associations between various study variables, including several links to the frequency of sexuality discussions. Variables showing significant correlations were further investigated using multiple linear regression analysis to assess their predictive contributions to the dependent variable.

## RESULTS

In this section, the findings of the study are presented in alignment with the sequence of the conducted analyses. Accordingly, results are organized under three main subsections. In the Scale Development subsection, Exploratory Factor Analysis (EFA) conducted on the exploratory items is explained and the psychometric properties of the newly constructed Perceived Competence and Comfort in Discussing Sexuality Scale (PCCDSS) are evaluated.

In the Preliminary Analysis subsection, descriptive statistics for the scores obtained from each and every scale is presented, data distributions are evaluated using normality tests, the effects of control variables are examined through independent samples t-tests and Welch's ANOVA, and correlations between the study variables are explored. Finally, in the Regression Model subsection, a multiple regression analysis is presented to evaluate the predictive power of the key independent variables on the dependent variable.

### 4.1. A PRELIMINARY SCALE DEVELOPMENT

#### 4.1.1. Exploratory Factor Analysis

An exploratory factor analysis (EFA) was conducted on the set of 13 exploratory items (see Table 4.1.). Principal axis factoring with an oblimin rotation was employed. The Kaiser–Meyer–Olkin (KMO) measure indicated meritorious sampling adequacy ( $KMO = .833$ ), and Bartlett's test of sphericity was significant,  $\chi^2(78) = 1337, p < .001$ , supporting the factorability of the correlation matrix.

**Table 4.1. Exploratory Factor Loadings of the Exploratory Items**

Item	Factor 1	Factor 2	Uniqueness
EX1	0.575		0.607
EX2	0.585		0.616
EX3	0.476		0.795
EX4	0.334		0.888
EX5	0.640		0.528
EX6	0.581		0.629
EX7	0.835		0.270
EX8	0.787		0.409
EX9	0.706		0.519
EX10	0.856		0.311
EX11		0.832	0.286
EX12		0.780	0.387
EX13		0.708	0.519

*Note.* 'Principal axis factoring' extraction method was used in combination with an 'oblimin' rotation.

Two factors had eigenvalues greater than 1 (4.68 and 1.09, respectively). However, the majority of items—specifically the first 10 items—loaded strongly onto the first factor, suggesting a dominant underlying construct related to competence and comfort in addressing sexuality in therapy. The first factor, labeled *Perceived Competence and Comfort in Discussing Sexuality*, consisted of items reflecting participants' self-perceived confidence, competence, and comfort in addressing sexuality-related issues in therapy sessions. Items loaded strongly onto this factor, with loadings ranging from .58 to .79.

During the analysis, three items (EX11, EX12, and EX13) were omitted due to their negative item-total correlations and weak factor loadings, which indicated that they did not coherently represent the underlying construct intended to be measured. Furthermore, based on face validity considerations, these three items differed conceptually from the other items: they focused more on client-specific aspects rather than therapists' general competence and comfort in addressing sexuality, thereby justifying their exclusion from the final scale.

#### 4.1.2. Evaluation of Validity and Reliability of PCCDSS

The Perceived Competence and Comfort in Discussing Sexuality Scale (PCCDSS) has demonstrated good validity. To begin with, the items (see Table 3.1.) are clear and exhibit strong face validity. Furthermore, the exploratory factor analysis (EFA; see Table 4.1.) supported high construct validity, with factor loadings ranging from .58 to .79. Additionally, scores on the PCCDSS were significantly correlated with nearly all of the study variables (to be described in greater detail later), thereby strengthening evidence for the scale's criterion validity.

**Table 4.2. Cronbach's  $\alpha$  for PCCDSS**

Scale	Number of Items	Cronbach's $\alpha$
Competence and Comfort Discussing Sexuality	10	.871

*Note. Higher scores indicate greater perceived competence and comfort in discussing sexuality.*

Furthermore, the internal consistency of the scale was excellent (see Table 4.2.), indicating very good reliability. Based on the factor structure and reliability statistics, the exploratory scale demonstrated sound psychometric properties for assessing perceived therapeutic competence and comfort regarding sexuality-related discussions in therapy. Therefore, a single-factor solution was interpreted, representing *Perceived Competence and Comfort Discussing in Sexuality*.

## 4.2. Preliminary Analysis

### 4.2.1. Descriptive Statistics

**Table 4.3. Descriptive Statistics for Key Variables**

---

Variable	<i>N</i>	Mean	<i>SD</i>	Minimum	Maximum
Age	201	31.6	5.25	24	54
Years in Profession	201	5.68	4.29	1	25
Education	201	1.64	1.35	0	6
Supervision	201	1.42	1.18	0	5
Clinical Experience	201	1.18	0.73	0	3
Sexuality Discussions	201	33.63	9.05	13	56

---

Descriptive statistics were conducted to summarize the demographic characteristics and key study variables (see Table 4.3.). The sample consisted of 201 participants ( $N = 201$ ). The mean age of participants was 31.6 years ( $SD = 5.25$ ), ranging from 24 to 54 years. The mean number of years in the profession was 5.68 ( $SD = 4.29$ ), with a range of 1 to 25 years. Participants scored a mean of 33.63 ( $SD = 9.05$ ) on the *Sexuality Discussions* measure, where the maximum possible score was 60. Participants' scores for sexuality education, sexuality supervision, and clinical experience with sexuality-related issues were generally low. Specifically, the mean score for sexuality education was 1.64 ( $SD = 1.35$ ), with scores ranging from 0 to 6. Similarly, the mean score for sexuality supervision

was 1.42 ( $SD = 1.18$ ), ranging from 0 to 5. Participants' scores of clinical experience in sexuality-related issues showed a mean of 1.18 ( $SD = .73$ ). Finally, participants' scores in PCCDSS showed a mean of 42.5 ( $SD = 8.5$ ) while the possible highest score of this particular scale was 60, meaning participants' perception of their competence and comfort discussing matters related to sexuality was generally high.

Due to the presence of diverse non-heteronormative sexual orientations among participants such as bisexual, gay, homosexual, and demisexual identities, the non-heterosexual orientations were grouped under the umbrella term *queer* to avoid insufficient group sizes for statistical analyses. Accordingly, a binary dummy variable named *Orientation* was created, categorizing participants as either *queer* or *heterosexual*. This dummy variable was used in subsequent analyses. Of the participants, 24 identified as *queer* and 177 as *heterosexual*.

#### **4.2.2. Normality and Linearity Assumptions**

Shapiro-Wilk tests and skewness–kurtosis evaluations were conducted to assess the normality of all continuous study variables. Results indicated that the dependent variable *Sexuality Discussions* was normally distributed,  $W = 0.994$ ,  $p = .613$ , with a *Skewness* score of 0.01 and *Kurtosis* score of  $-0.39$ ; making the distribution almost symmetrical.

*Age* (*Skewness* = 1.04, *Kurtosis* = 1.11), *Years in Profession* (*Skewness* = 1.49, *Kurtosis* = 2.54), *Education* (*Skewness* = 0.89, *Kurtosis* = 0.52), *Supervision* (*Skewness* = 0.82, *Kurtosis* = 0.52), *Family Discussions* (*Skewness* = 0.81, *Kurtosis* =  $-0.33$ ), *Culture Discussions* (*Skewness* =  $-0.08$ , *Kurtosis* =  $-1.26$ ) and *Perceived Competence and Comfort* (*Skewness* =  $-1.02$ , *Kurtosis* = 1.16) all showed mild to moderate values, within acceptable limits for parametric testing.

Dummy variables such as *Orientation* (*Skewness* = 6.23, *Kurtosis* = 36.9) and *Adult Speciality* (*Skewness* = 1.63, *Kurtosis* = 0.67) naturally violated normality assumptions due to their binary nature. However, additional normality checks from group comparisons confirmed that assumptions were met: Levene's test for the orientation groups was non-

significant,  $F(1, 199) = 0.0473$ ,  $p = .828$ , indicating equality of variances, and Welch's ANOVA for speciality groups indicated acceptable robustness despite slight deviations.

Scatterplots were examined for all predictors. For continuous predictors (*Education, Age, Years in Profession, Family Discussions, Culture Discussions, Perceived Competence and Comfort*), scatterplots demonstrated acceptable linear relationships with Sexuality Discussions. For dummy variables (*Orientation, Speciality*), scatterplots showed appropriate group separation, which is expected for categorical predictors.

No major deviations from linearity or homoscedasticity were observed taking the high number of participants ( $N = 201$ ) into consideration. Thus, assumptions for Spearman correlations and multiple regression analyses were deemed adequately met.

#### **4.2.3. Evaluation of Control Variables**

Control variables were evaluated to assess their associations with the frequency of *Sexuality Discussions* participants reported having with their clients. The categories of sexual orientation and speciality groups of the participants showed statistically significant differences, indicating that these variables should be included as control variables in subsequent regression analyses. In contrast, gender did not show a statistically significant association with *Sexuality Discussions* and thus will not be included as a control variable in the regression models.

##### **4.2.3.1. Effect of Gender on Sexuality Discussions**

An independent samples t-test was conducted to compare *Sexuality Discussions* scores between women and men. One participant who identified as nonbinary was excluded from the analysis due to insufficient group size. There was no significant difference between women ( $N = 177$ ,  $M = 33.40$ ,  $SD = 8.90$ ) and men ( $N = 23$ ,  $M = 34.80$ ,  $SD = 10.30$ );  $t(198) = -0.698$ ,  $p = .486$ ,  $d = -0.155$ . Levene's test indicated that the assumption of equal variances was met,  $F(1, 198) = 3.06$ ,  $p = .082$ .

#### 4.2.3.2. Effect of Sexual Orientation on Sexuality Discussions

**Table 4.4. Comparison of Sexuality Discussions by Therapists' Sexual Orientation**

Group	<i>N</i>	Mean	<i>SD</i>	SE
Queer	24	39.4	8.49	1.73
Heterosexual	177	32.9	8.87	0.666

An independent samples t-test was conducted to compare *Sexuality Discussions* scores between queer and heterosexual participants (see Table 4.4.). The results indicated a statistically significant difference between groups,  $t(199) = 3.40, p < .001$ . Specifically, queer participants ( $N = 24, M = 39.40, SD = 8.49$ ) reported significantly higher *Sexuality Discussions* scores compared to heterosexual participants ( $N = 177, M = 32.90, SD = 8.87$ ), with an approximate mean difference of 6.5 points. The effect size was large (*Cohen's d* = 0.739), suggesting a practically meaningful difference as well as a statistically significant one. Furthermore, Levene's test for equality of variances was non-significant,  $F(1, 199) = 0.047, p = .828$ , indicating that the assumption of homogeneity of variances was satisfied.

The size of the queer participant group ( $N = 24$ ) relatively small. For that reason, a post hoc power analysis was conducted for the comparison of sexual orientation groups on the relevant outcome variable. Despite the unequal group sizes, the observed effect size was moderate to large (*Cohen's d* = 0.74), and the achieved power was approximately 88%, indicating sufficient sensitivity to detect this difference. Nevertheless, the smaller sample size of the queer group should be considered when interpreting the generalizability of these findings.

Sexual orientation retained in subsequent analyses due to its statistically and practically significant effect on the dependent variable.

#### 4.2.3.3. Effect of Speciality Group on Sexuality Discussions

**Table 4.5. Post Hoc Comparisons for Different Levels of Speciality**

Comparison	Mean Difference	<i>p</i>
Adult vs. Child/Adolescent	10.3	.014
Child/Adolescent vs. Adult & Couple/Family	-13.08	.002
Child/Adolescent vs. Couple/Family & Child/Adolescent	-11.17	.009

A Welch's ANOVA was conducted to evaluate differences in *Sexuality Discussions* scores across different speciality groups. Results indicated a statistically significant effect,  $F(6, 12.0) = 3.86, p = .022$ . Post hoc analyses using Games-Howell tests (see Table 4.5.) revealed that participants specialized in child and adolescent therapy reported significantly lower sexuality discussion scores compared to other groups. However, there were only 9 participants who solely worked with children and adolescents.

Three separate dummy variables were created to indicate whether participants had each type of specialization. Among these variables, only *Adult Specialization* showed a significant correlation with the dependent variable. Therefore, it was decided to include having *Adult Specialization* as a control variable in the subsequent regression analyses. However, since the number of participants who are not specialized in working with the adult population is fairly low ( $N = 12$ ), caution is warranted when evaluating the generalizability of the particular findings.

#### 4.2.4. Correlations Between The Study Variables

**Table 4.6. Correlations Between the Main Study Variables**

Variable	1	2	3	4	5	6	7
1. Sexuality Discussions							
2. Sexual Orientation	.219**						
3. Years in Profession	.258***	-.156*					
4. Education	.296***	.063	.142*				
5. Supervision	.337***	.235***	.003	.418***			
6. Experience	.256***	.171*	.167*	.284***	.499***		
7. Perceived Competence and Comfort	.532***	.159*	.251***	.340***	.395***	.390***	

\*Note: \* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$

Spearman correlation analyses were conducted to examine the relationships among the study variables (see Table 4.6.). The results indicated that the strongest predictor of the dependent variable was *Perceived Competence and Comfort* ( $r = 0.532, p < .001$ ). Apart from that, *Sexuality Discussions* was positively correlated with *Age* ( $r = .252, p < .001$ ) as well, indicating that older psychotherapists tended to report more frequent sexuality discussions with clients. The dummy variable *Orientation* was also positively associated with *Sexuality Discussions* ( $r = .219, p < .001$ ), suggesting that queer psychotherapists were more likely to engage in sexuality discussions. Additionally, *Years in Profession* showed a positive correlation with *Sexuality Discussions* ( $r = .258, p < .001$ ), indicating

a tendency for individuals with longer professional experience to report higher frequencies of sexuality discussions. Similarly, *Adult Speciality* was positively correlated with *Sexuality Discussions* ( $r = .179, p = .011$ ), showing that participants specialized in therapy with the adult population were more likely to engage in these discussions. Moreover, clinical training variables were positively associated with *Sexuality Discussions*, as evidenced by significant correlations with *Education* ( $r = .296, p < .001$ ), *Supervision* ( $r = .337, p < .001$ ), and *Clinical Experience* ( $r = .256, p < .001$ ), highlighting their associations with the frequency of sexuality discussions.

In contrast, *Sexuality Discussions* was not significantly correlated with *Family Discussions* ( $r = .013, p = .856$ ), *Culture Discussions* ( $r = .045, p = .522$ ), *Sexual Esteem* ( $r = .081, p = .255$ ), *Sexual Depression* ( $r = .044, p = .954$ ), or *Sexual Attitude Total* ( $r = .036, p = .613$ ). On the other hand, *Sexual Preoccupation* ( $r = .139, p = .050$ ) showed a meaningful correlation with the dependent variable.

Beyond the associations with *Sexuality Discussions*, several significant correlations were observed among the predictor variables. As expected, *Age* and *Years in Profession* were strongly correlated ( $r = .797, p < .001$ ), indicating that older individuals tended to have more professional experience. The dummy variable *Orientation* was positively associated with *Supervision* ( $r = .235, p < .001$ ), suggesting that queer psychotherapists may be more likely than their heterosexual colleagues to have received supervision related to sexuality issues.

Furthermore, as it might be expected, *Family Discussions* was positively correlated with *Culture Discussions* ( $r = .363, p < .001$ ), indicating that clinicians who grew up in families open to discussing sexuality also tended to perceive their cultural background as open to sexuality discussions.

Moreover, *Education* was positively associated with *Supervision* ( $r = .418, p < .001$ ), and *Clinical Experience* was positively correlated with both *Supervision* ( $r = .499, p < .001$ ) and *Education* ( $r = .284, p < .001$ ), underscoring the interrelatedness of different components of clinical training.

**Table 4.7. Correlations with Perceived Competence and Comfort**

Variable 1	Variable 2	Spearman's r	p-value
Perceived Competence & Comfort	Sexuality Discussions	.532***	< .001
Perceived Competence & Comfort	Sexual Attitudes	.191**	< .01
Perceived Competence & Comfort	Sexual Esteem	.209**	< .01
Perceived Competence & Comfort	Sexual Depression	-.145*	< .05
Perceived Competence & Comfort	Education	.340***	< .001
Perceived Competence & Comfort	Supervision	.395***	< .001
Perceived Competence & Comfort	Experience	.365***	< .001
Perceived Competence & Comfort	Years in Profession	.251***	< .001

**Note.**  $p < .05$ ;  $p < .01$ ;  $p < .001$ . Only the main variables of the study are exhibited for clarity.

Apart from its own subscales, the total score given to *Sexual Attitudes* had only exhibited a strong correlation with *Perceived Competence and Comfort* ( $r = .191$ ,  $p < .01$ ). On the contrary, *Perceived Competence and Comfort* showed significant correlations with almost all the study variables (see Table 4.7.) including *Sexual Esteem* ( $r = .209$ ,  $p < .01$ ), and *Sexual Depression* ( $r = -.145$ ,  $p < .05$ ). This suggests that participants' perceptions of their comfort and competency around navigating sexuality discussions in their practice may be linked to their attitudes regarding their own sexuality.

### 4.3. The Regression Model

Assumption checks were controlled. With the original study variables, variance inflation factors (VIFs) were mostly below 2, except for *Age* (VIF = 3) and *Years in Profession* (VIF = 3.26), indicating some concerns on multicollinearity (see Table 4.8.). To maintain clarity in the model, *Age* was randomly chosen to be excluded as a predictor from the following analysis. After removing *Age* from the predictor list (see Table 4.9.), 8 potential predictors remained: *Education*, *Supervision*, *Experience*, *Adult Speciality*, *Orientation*, *Years In Profession*, *Sexual Preoccupation* and *Perceived Competence and Comfort*.

**Table 4.8. Collinearity Statistics Including Age**

	VIF	Tolerance
Education	1.29	0.777
Supervision	1.73	0.580
Experience	1.59	0.630
Perceived Comfort & Competence	1.46	0.684
Orientation	1.11	0.904
Adult Speciality	1.13	0.886
Sexual Preoccupation	1.03	0.968
Age	3.00	0.333
Years in Profession	3.26	0.307

**Table 4.9. Collinearity Statistics Excluding Age**

	VIF	Tolerance
Years in Profession	1.17	0.856
Orientation	1.10	0.905
Adult Speciality	1.11	0.898
Education	1.28	0.782
Supervision	1.72	0.580
Experience	1.59	0.630
Sexual Preoccupation	1.03	0.968
Perceived Comfort & Competence	1.46	0.686

Moreover, The visual confirmation of the Q–Q plot illustrating the distribution of the standardized residuals against the theoretical quantiles supports the *Shapiro-Wilk test* result ( $W = .992, p = .372$ ), suggesting no significant deviations from normality and satisfying a key assumption of multiple linear regression.

A multiple linear regression analysis was conducted to examine the predictors of *Sexuality Discussions* (see Table 4.10.). The overall model was significant,  $F(8, 193) = 15.2, p < .001$ , explaining approximately 38.8% of the variance in *Sexuality Discussions* ( $R^2 = .388, adjusted R^2 = .363$ ).

**Table 4.10. Model Fit Measures**

Model	R	R <sup>2</sup>	Adjusted R <sup>2</sup>
1	.623	.388	.363

**Table 4.11. Factors Predicting the Frequency of Sexuality Discussions**

Predictor	<i>B</i>	95% CI for <i>B</i>	<i>SE</i>	$\beta$	<i>t</i>	<i>p</i>
Intercept	7.21	[ 1.11, 13.31 ]	3.11		2.32	= .022
P. Competence & Comfort	.38	[ .22, .49 ]	.07	.35	5.19	< .001
Years in Profession	.44	[ .09, .33 ]	.13	.21	3.40	< .001
Orientation	4.10	[ .03, .26 ]	1.65	.14	2.48	= .014
Adult Speciality	3.69	[ -.01, .23 ]	1.93	.11	1.90	= .058
Education	.80	[ -.01, .23 ]	.43	.12	1.86	= .064
Supervision	.89	[ -.04, .26 ]	.57	.11	1.47	= .143
Clinical Experience	.03	[ -.14, .13 ]	.89	.01	.03	= .971
Sexual Preoccupation	.17	[ -.04, .18 ]	.14	.01	1.23	= .221

*Note.* CI = confidence interval for *B*; SE = standard error;  $\beta$  = standardized beta coefficient.

Among the predictors (see Table 4.11.), *Perceived Competence and Comfort* emerged as the strongest and most significant predictor ( $\beta = .376, p < .001$ ), indicating that therapists who reported higher levels of comfort and competence were significantly more likely to engage in sexuality discussions. Years in the Profession as well, emerged as a strong predictor ( $\beta = .437, p < .001$ ). Additionally, queer-identifying therapists (*Orientation*, coded 1) reported significantly more sexuality discussions compared to heterosexual therapists ( $\beta = 4.098, p = .014$ ).

Other predictors, including *Supervision* ( $\beta = .839, p = .143$ ), *Clinical Experience* ( $\beta = .033, p = .971$ ), and *Sexual Preoccupation* ( $\beta = .174, p = .221$ ) were not statistically significant in the model. *Education* ( $\beta = .799, p = .064$ ) and *Adult Speciality* ( $\beta = 3.690, p = .058$ ) were marginally significant. This may suggest that therapists' level of education in sexuality and that whether they see adult clients or not might have an effect on the frequency of sexuality discussions with clients.

Overall, these findings underscore the central role of the number of years therapists have been in the profession, as well as their perceived competence and comfort in discussing sexuality with clients, in facilitating more frequent sexuality-related discussions. Furthermore, the results highlight the influence of therapists' sexual orientation — specifically whether they identify as heterosexual or non-heterosexual — on the extent to which they engage in sexuality-related conversations with their clients.

#### **4.4. Exploratory Analysis**

Another multiple linear regression analysis was conducted to examine the predictors of *Sexuality Discussions* when Perceived Competence and Comfort was removed from the predictor list. The overall model was significant,  $F(7, 193) = 12.0, p < .001$ ; explaining approximately 30.3% of the variance in *Sexuality Discussions* ( $R^2 = .303, adjusted R^2 = .277$ ), 8.5 points lower in percentage than the original model.

In this model, together with *Years in Profession* ( $\beta = .587, p < .001$ ) and *Orientation* ( $\beta = 5.047, p = .004$ ); clinical training variables *Education* ( $\beta = 1.197, p = .008$ ) and *Supervision* ( $\beta = 1.308, p = .030$ ) were also statistically significant. These results would suggest that being queer, being a seasoned psychotherapist, having more undergraduate-level education on sexuality, and having received more supervision on sexuality issues significantly predict higher levels of sexuality discussions with clients.

Notably, the exclusion of the *Perceived Competence and Comfort* variable revealed effects of *Education* and *Supervision*, which had not emerged as significant predictors previously. This suggests that the effect of clinical training on the frequency of sexuality

discussions clinicians have with their clients may be mediated by their perceived comfort and competence in navigating these discussions.

## DISCUSSION

This study aimed to explore the factors that are associated with psychotherapists' tendency to engage in sexuality-related discussions with clients. Both clinical training variables (e.g., supervision), therapist characteristics (e.g., sexual attitudes), and demographic variables (e.g., sexual orientation) were included as potential predictors. The dependent variable was therapists' self-reported frequency of sexuality-related discussions in clinical practice.

Given the limited empirical research on this topic within the Turkish context, this study adopted an exploratory approach. The literature lacks Turkish scales reflecting therapist perspectives or attitudes towards sexuality as a therapeutic conversation topic. Therefore, a set of additional items was included in the questionnaire to address dimensions that existing literature from Western contexts had often explored. A preliminary scale, labeled PCCDSS was constructed by incorporating these exploratory items developed for the present study. Then, the composite score of PCCDSS labeled *Perceived Competence and Comfort* was also added to the predictor list. This exploratory component of the study, while not tied to specific hypotheses, offered insight into potential underlying constructs relevant to the topic that aligned with prior literature.

Based on prior literature from other contexts, the study hypothesized that therapists with greater professional exposure—via years of experience, sexuality-related education, supervision, and clinical encounters—would be more likely to engage in such discussions. Similarly, it was expected that therapists from more open family and cultural backgrounds, and those with more positive sexual attitudes, would report higher discussion frequency. Therapists' age, gender, sexual orientation, and specialization group (the population they work with) were included as control variables.

This section will begin by presenting the preliminary scale development process and interpreting related findings. Subsequently, it will report first the results pertaining to the pre-defined hypotheses, followed by exploratory findings, situating them within comparisons to the existing literature. Finally, the section will conclude with an

interpretation of the implications for theory, practice, and future research, along with a discussion of the study's limitations.

## **5.1. Perceived Competence and Comfort Discussing Sexuality Scale: PCCDSS**

### **5.1.1. Conceptual Basis**

The questionnaire used in this study included 13 additional items in addition to the pre-constructed scales measuring therapists' levels of graduate-level sexuality education, supervision, and clinical experience related to sexuality issues; as well as therapists' own sexual attitudes (sexual-esteem, sexual-depression, and sexual-preoccupation); and demographic information.

These additional items were not designed to operationalize a predefined construct; rather, they were included to capture therapists' own perspectives on sexuality-related discussions, thereby allowing for an examination of their influence within psychotherapy practice. Earlier research on sexuality discussions in therapy (Cupit, 2010; Graham & Smith, 1984; Harris & Hays, 2008; Miller & Byers, 2008, 2012; Reynolds et al., 2005; Shafir et al., 2022; Træen & Schaller, 2013) has consistently investigated how therapists' personal experiences and attitudes towards these conversations alongside clinical training factors shape these conversations. Thus, the inclusion of these exploratory items was driven by their theoretical relevance.

A range of measurement tools has been developed to assess therapists' comfort, their willingness to address sexual topics with clients, and their beliefs and attitudes about incorporating sexuality into therapeutic work. However, currently there are no original nor adapted scales available in Turkish. The aim was to obtain a broader and more contextually grounded understanding of how sexuality-related topics are addressed in psychotherapy practice in Türkiye.

### **5.1.2. Empirical Basis**

To examine whether these exploratory items shared an underlying structure, a principal component analysis was conducted. This analysis revealed two distinct clusters of related items, suggesting the presence of more than one underlying theme. However, most items—particularly the first 10—appeared to reflect a common dimension, pointing to a dominant underlying factor. This factor was labeled *Perceived Competence and Comfort in Discussing Sexuality*, as it encompassed items assessing clinicians' self-reported confidence, competence, and comfort in addressing sexuality-related topics during therapy.

The internal consistency of this factor was high, with item loadings indicating that each item made a strong contribution to the underlying construct. Based on these results, a composite score labeled *Perceived Competence and Comfort* was calculated by summing the responses to the 10 items that loaded strongly on this factor.

The structure and item loadings of the original preliminary scale PCCDSS are illustrated in tables numbered 4.1. and 4.2.. PCCDSS demonstrated good psychometric properties and theoretical relevance. As a result, the scores from the preliminary scale was included in the analysis as a potential predictor of the frequency of sexuality discussions.

## **5.2. Factors Affecting The Frequency of Sexuality Discussions With Clients**

A multiple regression analysis was constructed to examine the predictors of the frequency of sexuality-related discussions therapists engage with clients. The model met key statistical assumptions, with no serious multicollinearity issues and normally distributed residuals, proving that the model's estimations can be considered robust and interpretable.

In the regression model, three predictors were found to significantly predict the frequency of sexuality discussions : the length of time therapists have worked in the profession, their perceived competence and comfort in addressing sexuality with clients, and their sexual

orientation. The overall model accounted for approximately 38.8% of the variance in the dependent variable, indicating a relatively high level of explanatory power.

As an exploratory additional component, the multiple regression analysis was repeated with the perceived competence and comfort factor excluded. As it was expected, variables related to formal clinical training — specifically sexuality-related education and supervision — gained predictive power following this exclusion.

### **5.2.1. Predictors of Sexuality Discussions**

#### **5.2.1.1. Clinical Training (Education and Supervision)**

These results partially supported the hypotheses that education and supervision would positively predict sexuality discussions, both associated with increased likelihood of engaging in these discussions. In the main regression analysis, education was marginally significant; although not reaching, close to the conventional threshold. This means that higher education might increase sexuality discussions. On the contrary, supervision factor did not showed to be a predictor.

However, when the Perceived Competence and Comfort variable was removed from the model, Education and Supervision variables emerged as significant predictors, whereas they had not shown significant effects before. This suggests that the influence of clinical training on how often clinicians address sexuality with clients may be mediated by their perceived comfort and competence in these conversations. This trend aligns with patterns observed in previous research.

Miller and Byers (2012) examined the mechanisms through which sexuality-related training influences psychotherapists' clinical behavior. They found that higher levels of sexuality-related education increased therapists' engagement in sexual discussions by enhancing their sexual intervention self-efficacy—a term describing the therapist's confidence in addressing sexual issues with clients. Moreover, Harris and Hays (2008) found that while psychotherapists' comfort discussing sexuality significantly influences

how often they engage in these discussions; sexuality education, supervision experience, and perceived sex knowledge collectively accounted for 48% of the variance in therapists' comfort levels regarding sexuality-related issues.

These findings are also consistent with previous studies emphasizing the importance of targeted education and supervisory experiences (Cupit, 2010; Harris & Hays, 2008; Miller & Byers, 2012; Træen & Schaller, 2013). In the literature, it is repeatedly demonstrated that a lack of professional sexuality education (McClure, 2012) and insufficient clinical training in sexuality-related issues (Timm, 2009) are among the main reasons why therapists feel uncomfortable discussing sexual matters with clients. In fact, according to the existing literature (Cupit, 2010; Harris & Hays, 2008; Miller & Byers, 2012) education and supervision may be considered the most robust and frequently reported predictors of sexuality discussions in psychotherapy settings.

#### **5.2.1.2. Therapists' Perception Of Their Competence and Comfort**

Among all predictors, perceived competence and comfort emerged as a strong and statistically significant factor, suggesting that therapists who feel more confident and competent in addressing sexuality are substantially more likely to do so in clinical practice. Consistent with these results, Harris and Hays (2008) concluded that as therapists' comfort discussing sexual topics improve, they become more likely to engage in these conversations with their clients. Moreover, according to D'Arrigo (2021), clinicians' own discomfort with sexuality discussions together with a lack of education are the two main challenges to these discussions.

#### **5.2.1.3. Years (Years in Profession and Age)**

In line with the initial hypothesis, therapists' years in the profession significantly predicted the frequency of sexuality-related discussions among therapists, a finding that is consistent with previous literature. For example, Cupit (2010) reported a positive

association between clinical experience and the frequency of addressing sexuality in therapeutic conversations.

Therapists' age, on the other hand, was initially treated as a control variable; however, correlational analyses revealed a strong association with the dependent variable. Conceptually, age and years in the profession are likely to overlap substantially, which was also reflected in elevated VIF values indicating multicollinearity risk. Therefore, age was excluded from the predictor list to avoid redundancy.

Although therapist age is not frequently highlighted as a strong predictor in the literature, Cupit's (2010) study with family counselors suggested that older therapists may generally engage in sexuality discussions more often than their younger colleagues. Taken together, these findings suggest that being a more seasoned professional — whether through age, years of practice, or both — may contribute to more frequent sexuality-related conversations in therapy.

#### **5.2.1.4. Therapist's Sexual Orientation**

In the present study, sexual orientation was initially included in the model as a control variable and was not tied to a specific hypothesis. However it suggested a significant predictive role in psychotherapist tendencies at navigating sexuality discussions. Specifically, the results suggests that queer (as in non-heterosexual) therapists may engage more with sexuality discussions with their clients compared to their heterosexual counterparts.

The sample size for the queer group was relatively low, meaning a caution is warranted in generalizing these findings. However, the statistical power was sufficient to detect a moderate-to-large difference. This suggests the observed effect is meaningful despite the sample size discrepancy.

The literature investigating the influence of therapist's own sexual orientation on their handling of sexuality discussions in therapy settings is limited if not absent. Thus, the

findings regarding the effect of therapist's sexual orientation in the frequency of sexuality discussions represents a novel contribution of the present study.

## **5.2.2. Non-Determinants of Sexuality Discussions**

### **5.2.2.1. Clinical Experience with Sexuality**

To avoid conceptual confusion, it is important to distinguish between the variables of clinical experience and sexuality discussions -the dependent variable itself. The "clinical experience" variable reflects how frequently clinicians work with cases involving sexuality-related issues. In contrast, the dependent variable of "sexuality discussions" captures how often therapists actively engage in conversations covering various aspects of sexuality during therapy, regardless of whether the client initially presents with a sexuality-related concern.

Clinical experience with sexuality was not a significant predictor in this model, contrary to the study's original hypothesis. Despite showing significant correlations in earlier analyses, its predictive value diminished when other variables were controlled for. This discrepancy suggests that while the amount of clinical encounters may relate to sexuality discussions at a bivariate level, it does not independently account for variance in the dependent variable within the multivariate context. Meaning, the level of therapists' clinical experience with sexuality-related issues does not appear to be a determining factor in how routinely they engage in discussions and assessments of various aspects of clients' sexuality within the therapeutic process.

Some of the previous studies on therapist engagement with sexuality discussions (Cupit, 2010; Moore, 2018) suggest that psychotherapists with prior clinical experience in addressing sexuality issues are more likely to exhibit higher levels of comfort and confidence when discussing sexual topics in therapy. However, another study (Hanzlik & Gaubatz, 2012) with Clinical PsyD trainees suggested that more clinical experience was not correlated with higher comfort discussing sexuality with patients. Moreover, Harris

and Hays (2008) found couple and family therapists' clinical experience to be not meaningful at predicting their frequency of sexuality discussion in therapy.

#### **5.2.2.2. Sexual Attitudes**

Also in contrast to the study's hypotheses, therapists' sexual attitudes—including sexual self-esteem, sexual depression, and sexual preoccupation—did not emerge as significant predictors in the initial regression model. This was contrary to the study's hypothesis, which had anticipated a positive predictive relationship between sexual attitudes and sexuality discussions.

However, despite sexual attitudes not emerging as a valid predictor itself, it still presented some meaningful indications. Therapists' perception of their comfort and competence in navigating sexuality discussions in therapy was a significant predictor, and therapists' sexual attitudes showed significant correlations with this particular factor. This may suggest that therapists' sexual attitudes could indirectly influence their engagement in sexuality-related conversations through their perceived competence and comfort.

Clinicians' personal attitudes, beliefs, and habits regarding sexuality have been discussed in earlier literature, though the findings have not been entirely consistent. While some studies have questioned the impact of therapists' personal sexual values on clinical work (Moore, 2018), much of the literature indicates that sexual attitudes are linked to therapists' comfort and willingness to engage in sexuality-related discussions (Cupit, 2010; Ford & Hendrick, 2003; Hanzlik & Gaubatz, 2012). Notably, Hanzlik and Gaubatz (2012) found that for clinical PsyD trainees, sexual attitudes influenced comfort levels more than clinical experience or training, and Cupit (2010) reported modest associations between specific sexual attitudes and the frequency of addressing sexuality in therapy.

#### **5.2.2.3. Discussions in Family and Culture**

Participants were asked to rate, on a Likert-type scale, the perceived openness of sexuality-related conversations and disclosures both within their family of origin and in

their broader cultural environment during their upbringing. According to the original hypothesis of the study, it was anticipated that participants who perceived their familial and cultural environments as open to sexuality discussions would be more likely to engage in such discussions with their clients in clinical practice. Contrary to this hypothesis, the analysis did not reveal a statistically significant effect of these variables on the dependent variable. It is important to note that, due to the lack of validated Turkish scales in this area, both variables were assessed through single-item measures. The possible effects of this will be further discussed in the Limitations section.

The literature reveals a gap from a quantitative perspective in examining the influence of therapists' cultural backgrounds or family communication patterns on their clinical engagement with sexuality-related topics. However, using qualitative approaches the effects of complex therapist characteristics such as religious and spiritual beliefs, family upbringing and early relational environments have been explored (Berman-Brodsky, 2022; Naughton, 2022), and findings suggest they may influence therapists' comfort levels in addressing sexual topics during sessions. For instance, Berman-Brodsky (2022) emphasized that the way sexuality was approached within the family during one's formative years could shape later professional attitudes toward such discussions in adulthood. Relatedly, in a study evaluating the outcomes of a group supervision initiative in sex therapy, Shafrir and Balahur (2022) reported that therapists with religious affiliations had greater anxiety and a higher perceived need for supervision compared to their non-religious peers. Nonetheless, quantitative research exploring these influences remains scarce.

### **5.3. Contributions and Implications**

One of the most prominent contributions of this study is the development of a preliminary scale in Turkish designed to assess therapists' levels of perceived comfort and competence in discussing sexuality (PCCDSS). PCCDSS demonstrated promising psychometric properties, with satisfactory evidence of its initial validity and reliability. However, to support its continued use in future research and practice, it would be valuable

to further examine its test-retest stability, ensuring that the measure reliably captures therapists' attitudes and competencies over time. Subsequent studies may also consider refining and expanding this preliminary scale, potentially enhancing its items and structure to better reflect nuances of sexuality discussions within therapeutic contexts. Such efforts would strengthen the scale's utility and contribute to building a more robust evidence base for addressing sexuality in psychotherapy, particularly in settings similar to Türkiye.

Another major contribution of this study is that; to our knowledge, this study represents the first empirical investigation into how sexuality-related topics are addressed in psychotherapeutic practice in Türkiye. The findings suggest that, overall, Turkish therapists exhibit characteristics similar to those described in the existing literature from international contexts. The observed frequency of sexuality discussions, while requiring more direct cross-cultural comparisons, appears to align with international trends.

Among the key factors influencing sexuality-related discussions with clients were graduate-level sexuality education, supervision in sexuality related topics, and therapist's perceived competence and comfort in discussing sexuality. These variables have also been repeatedly identified in the previous research conducted in settings outside of Türkiye (Cupit, 2010; Harris & Hays, 2008; Miller & Byers, 2012). Their recurrence here may reflect a degree of universality in what facilitates therapists' engagement with sexuality in clinical work.

The role of clinical training—specifically sexuality-related education and supervision—is widely emphasized in the literature as central to increasing therapists' readiness and comfort in addressing sexual topics (Cupit, 2010; Harris & Hays, 2008; Miller & Byers, 2012; Træen & Schaller, 2013). The findings of this study aligned with the prior literature showing that sexuality-related clinical training meaningfully predicts therapists' frequency of sexuality discussions with clients. Despite the importance of clinical training, most participants in this study reported low levels of such training, highlighting a significant gap in the current structure of psychotherapy education in Türkiye. As seen globally—for example, in the United States (Abbott et al., 2021) and United Kingdom

(Shaw et al., 2008)—sexuality is frequently omitted from the core content of clinical psychology programs. This lack of clinical training—and the absence of structured opportunities for open dialogue it entails—may contribute to therapists' reduced engagement with sexuality topics in their practice. Given the critical role of sexuality in mental health, there is a clear need for more comprehensive opportunities for clinical training.

Notably, when the perceived competence and comfort factor was added to the regression model, the predictive power of clinical training variables education and supervision was no longer statistically significant. This may suggest that the impact of training on discussion frequency is not primarily about the accumulation of factual or academic knowledge, but rather about enhancing therapists' internal sense of ease and efficacy when addressing sexual topics in therapy. In this light, education and supervision may serve more as mechanisms for building experiential comfort than as traditional routes of content delivery. This interpretation is consistent with the results of previous studies that have questioned the predictive utility of "sexual knowledge" as a stand-alone variable in clinical behavior (Cupit, 2010; Harris & Hays, 2008). Instead, it appears that the most meaningful outcome of training may be the cultivation of a therapist's confidence and readiness to broach sensitive topics. These findings underscore the importance of examining comfort as a potential mediating variable in future research, ideally through studies employing formal mediation analysis techniques to better understand these indirect pathways.

Moreover, more years in the profession was also a significant predictor of the frequency of sexuality discussions in therapy. However, it should be noted that since therapists' age and their years in the profession largely overlap conceptually, age was excluded from the analysis to avoid redundancy. Being a more experienced therapist — whether due to age, time in practice, or both — may be linked to more frequent discussions of sexuality in therapy. The findings of the present study suggests that more seasoned therapists may discuss sexuality more frequently than their younger counterparts. This finding, as well, might be concluded to be in alignment with prior research (Cupit, 2010).

In contrast, the predicting role of therapist's sexual orientation on the frequency of sexuality discussions they have with clients can be considered a new finding. There is a noticeable gap in the literature regarding how therapists' own sexual orientation may shape their willingness or ability to engage in sexuality-related discussions during therapy. Therefore, the current study's observation that sexual orientation appears to meaningfully influence discussion frequency stands out as a unique contribution.

The observed effect of queer identity as a predictor of higher discussion frequency may reflect the greater salience of sexuality as a life theme among LGBTQ+ therapists. In other words, queer therapists are likely more accustomed to thinking about and discussing sexuality due to personal, social, or political factors in their lived experiences. As a result, they may feel more confident and equipped to initiate or navigate sexuality-related conversations in therapy, which could directly influence the frequency with which they address these topics with clients.

This contribution can be also viewed through a cultural perspective. Variations in cultural context may help account for differences between these findings and those in prior studies. Specifically, the Turkish sociocultural landscape — with its particular values and sensitivities around sexual topics — may shape therapists' professional attitudes and behaviors in distinct ways compared to Western societies like the United States or Europe. It is conceivable that in Türkiye, queer-identified therapists feel comparatively more at ease initiating or navigating sexuality-related conversations with clients than their heterosexual peers do, whereas this tendency might not emerge similarly in settings with different cultural frameworks. However, it should be noted that these interpretations are in some level speculative.

Interestingly, while sexual attitudes did not significantly predict the frequency of sexuality-related discussions in the regression analysis, they were found to be significantly associated with therapists' perceived competence and comfort in discussing sexuality. This suggests that therapists' attitudes toward their own sexuality may be linked to how comfortable they feel addressing sexual topics in a professional setting. Although not always consistent, the literature has often reported associations between sexual

attitudes or sexual values and therapists' clinical behavior towards sexuality (Cupit, 2010; Ford & Hendrick, 2003; Hanzlik & Gaubatz, 2012). The indirect association revealed in the present study—between sexual attitudes and therapists' perceived competence and comfort in discussing sexuality— might highlight a potentially meaningful pathway. Future research should further explore this intriguing relationship and consider how personal attitudes toward sexuality might shape therapeutic behavior through internal comfort mechanisms.

All in all, this study provides a layered understanding of how various personal and professional factors may shape therapists' engagement with sexuality in the clinical context. The main finding of this study is that therapists' levels of sexuality-related education and supervision experiences seem to converge in shaping therapists' comfort, competence, and frequency in addressing sexual issues with their clients. Such a multifaceted picture underscores the need for both individual-level awareness and systemic support structures within the profession.

Against this backdrop, broader sociocultural forces must also be considered. The ongoing taboo status of sexuality in Turkish society, and the limited attention it receives even in formal clinical training programs, likely perpetuates therapist avoidance. Avoidance begets further avoidance, reducing both the visibility and legitimacy of sexuality as a therapeutic issue. Integrating sexuality content into training curricula and supervision processes may help normalize such discussions, ultimately facilitating therapists' readiness to address these themes. Given the critical importance of sexuality for individuals' well-being, relationships, and psychological health, increasing these conversations in therapy has substantial clinical value (Harris & Hays, 2008; Love & Farber, 2017).

On a practical level, these findings can inform the development of training modules and supervision programs tailored to therapists in Türkiye. Group supervision models focused on sexuality have been shown to enhance therapists' self-efficacy and improve attitudes toward sexual topics (Shafirir & Balahur, 2022). In Türkiye as well, similar initiatives could be implemented through the integration of structured group supervision modules

into therapist training programs, potentially offering a safe and guided environment for discussing sexuality-related topics in clinical practice.

These findings may also suggest several directions for future research. Qualitative studies could explore how therapists build comfort in discussing sexuality; longitudinal research could track changes in comfort over time; and experimental designs could test the effectiveness of sexuality-focused training interventions.

#### **5.4. Limitations and Directions For Future Research**

While the present study offers valuable insights into the predictors of sexuality-related discussions in psychotherapy within the Turkish context, several limitations should be acknowledged to appropriately contextualize its findings and inform future research.

First and foremost, the use of a convenience sampling strategy may limit the generalizability of the findings. Participants were self-selected through online platforms, which may have attracted therapists who already have an interest or comfort with discussing sexuality, potentially skewing the results. Additionally, the response rate for the survey was relatively low, which could further contribute to concerns about selection bias. Therapists who felt more comfortable with the topic may have been more inclined to participate, potentially skewing the findings.

Furthermore, the sample, although adequately powered, it cannot be claimed that it was demographically representative of all psychotherapists in Türkiye in terms of geographic distribution, institutional background, or theoretical orientation. As one of the first studies in Türkiye to explore sexuality discussions in psychotherapy, this research serves as a foundational base for future empirical work in the field. It is plausible that therapists' engagement with sexuality in their clinical practice may vary according to their geographic location, institutional affiliation, or theoretical orientation. These contextual factors may shape not only therapists' attitudes and comfort but also their needs. Therefore, future studies should aim to explore these subgroup differences through larger and more representative surveys. Such investigations could illuminate the specific

challenges and educational gaps faced by diverse therapist populations across Türkiye, contributing to the development of more tailored and effective training programs.

Moreover, the predictive power of certain categorical variables—particularly sexual orientation—may be interpreted with caution due to uneven group sizes. Although queer therapists reported significantly higher discussion frequencies, the number of queer-identifying participants ( $N = 24$ ) was relatively small. Even though the statistical power was sufficient to detect a moderate-to-large difference, future studies with more balanced and diverse samples should replicate these findings to provide greater generalizability of this particular finding.

Another limitation of the present study lies in the lack of previously adapted Turkish scales measuring constructs related to the study's aims. The absence of localized tools may have posed limitations to measurement precision, particularly for one-item constructs like family and culture discussions. Contrary to the study's hypotheses, the analyses revealed no meaningful effect of these factors on the frequency of sexuality discussions in therapy. However, even if these factors did influence the frequency of sexuality discussions, the present research might have been insufficient to capture this effect.

Additionally; given the sensitivity of the topic, participants may have overreported their comfort levels or frequency of sexuality discussions due to social desirability concerns. Although anonymity was emphasized, the self-report nature of the data collection remains a limitation. Incorporating implicit measures or observational methods could offer more nuanced insights into therapist behavior.

Another key limitation is the study's cross-sectional nature, which restricts causal inference. While multiple regression allows for the assessment of predictive relationships, it cannot determine temporal or causal directions. For instance, although the results suggest that education and supervision contribute to higher competence and comfort, it is also plausible that more confident therapists are more likely to seek such training opportunities. Longitudinal studies are needed to clarify these dynamics over time.

## CONCLUSION

This study investigated the predictors of sexuality-related discussions in psychotherapy within the Turkish context, utilizing a survey of 201 therapists. The results indicated that therapist's perception of their competence and comfort in relation to those discussions, their years in the profession, and clinical training variables—specifically, education and supervision— were significant predictors of therapists' engagement with sexuality in therapy. This result is reflected in earlier studies from international contexts. While therapist's sexual orientation was added in the study as a potential control variable, it emerged as a meaningful contributor. This may be due to greater personal and social familiarity of sexuality to queer participants, with Türkiye's cultural context possibly reinforcing this pattern, though this explanation is partly speculative.

Furthermore, an indirect association between sexual attitudes and therapist comfort suggested a deeper connection between personal attitudes and professional behavior regarding the topic of sexuality. Additionally, the exploratory analysis provided partial evidence that therapist's self-confidence (or preceived competence and comfort in the present case) in discussing sexuality may mediate the relationship between clinical training on sexuality and the frequency of related conversations therapists have in therapy, consistent with findings from studies conducted outside of Türkiye (Miller & Byers, 2012).

This study, as the first empirical study of its kind conducted in Türkiye, may offer a baseline for the empirical understanding of how and how much sexuality is being adressed in clinical settings. By mapping the key individual and training-related predictors, this research may establish a foundational empirical basis for future studies on sexuality in psychotherapy within the Turkish context.

The other key contribution of this study is the development of the Turkish PCCDSS scale to assess therapists' perceived comfort and competence in discussing sexuality, showing

promising initial validity and reliability. Future research should examine its test-retest stability to strengthen its utility.

Moreover, the findings of the study highlight the potential value of shifts in existing educational models to better integrate sexuality into the core of psychotherapy training. Through its theoretical framework, this study suggests that conversations about sexuality are both relevant and necessary in mental health care. Moreover, the theoretical framework hints at that with the right training and increased opportunities for the open discussions about sexuality that it would provide, therapists in Türkiye may become better prepared to engage with this essential aspect of human well-being in their practice.

## REFERENCES

- Abbott, D. M., Mollen, D., Anaya, E. J., Burnes, T. R., Jones, M. M., & Rukus, V. A. (2021). Providing sexuality training for psychologists: The role of predoctoral internship sites. *American Journal of Sexuality Education, 16*(2), 161-180.
- Akman, R. Y., Çelik, E. C., & Karataş, M. (2015). Sexuality and sexual dysfunction in spinal cord-injured men in Türkiye. *Turkish Journal Of Medical Sciences, 45*(4), 758-761.
- Allen, M. S., & Walter, E. E. (2018). Linking big five personality traits to sexuality and sexual health: A meta-analytic review. *Psychological Bulletin, 144*(10), 1081–1110. <https://doi.org/10.1037/bul0000157>
- Andersson, M., & Iwasa, Y. (1996). Sexual selection. *Trends in ecology & evolution, 11*(2), 53-58.
- Bach, L. E., Mortimer, J. A., VandeWeerd, C., & Corvin, J. (2013). The association of physical and mental health with sexual activity in older adults in a retirement community. *The Journal Of Sexual Medicine, 10*(11), 2671-2678.
- Bahnsen, M. K., Graugaard, C., Andersson, M., Andresen, J. B., & Frisch, M. (2022). Physical and mental health problems and their associations with interpersonal sexual inactivity and sexual dysfunctions in Denmark: baseline assessment in a national cohort study. *The Journal Of Sexual Medicine, 19*(10), 1562-1579.
- Bailey, J. M., Vasey, P. L., Diamond, L. M., Breedlove, S. M., Vilain, E., & Epprecht, M. (2016). Sexual orientation, controversy, and science. *Psychological Science In The Public Interest, 17*(2), 45-101.

- Berman-Brodsky, S. (2022). The importance of talking about sex with clients. *Immaculata University*.
- Behun, R. J., Cerrito, J. A., Delmonico, D. L., & Campenni, E. (2017). Curricular abstinence: examining human sexuality training in school counselor preparation programs. *Journal of School Counseling, 15*(14), n14.
- Birnbaum, G. E. (2010). Bound to interact: the divergent goals and complex interplay of attachment and sex within romantic relationships. *Journal of Social and Personal Relationships, 27*(2), 245-252.
- Birnbaum, G. E., Reis, H. T., Mikulincer, M., Gillath, O., & Orpaz, A. (2006). When sex is more than just sex: attachment orientations, sexual experience, and relationship quality. *Journal Of Personality And Social Psychology, 91*(5), 929.
- Biss, W., & Horne, S. (2005). Sexual satisfaction as more than a gendered concept: The roles of psychological well-being and sexual orientation. *Journal of Constructivist Psychology, 18*(1), 25–38. <https://doi.org/10.1080/10720530590523044>
- Botha, K. (2023). Our identities under arrest: a global overview on the enforcement of laws criminalising consensual same-sex sexual acts between adults and diverse gender expressions. *ILGA*. <https://ilga.org/our-identities-under-arrest/>
- Boyacıoğlu, N. E., Oflaz, F., Karahmet, A. Y., Hodacı, B. K., Afşin, Y., & Taşabat, S. E. (2023). Sexuality, quality of life and psychological well-being in older adults: a correlational study. *European Journal Of Obstetrics & Gynecology And Reproductive Biology: X, 17*, 100177.

- Bridge, L., Smith, P., & Rimes, K. A. (2019). Sexual orientation differences in the self-esteem of men and women: a systematic review and meta-analysis. *Psychology of Sexual Orientation and Gender Diversity*, 6(4), 433.
- Brody, S. (2003). Alexithymia is inversely associated with women's frequency of vaginal intercourse. *Archives of Sexual Behavior*, 32, 73–77.
- Brody, S., & Preut, R. (2003). Vaginal intercourse frequency and heart rate variability. *Journal of Sex & Marital Therapy*, 29, 371–380.
- Christensen, B. S., Grønbæk, M., Osler, M., Pedersen, B. V., Graugaard, C., & Frisch, M. (2011a). Associations between physical and mental health problems and sexual dysfunctions in sexually active Danes. *The journal of sexual medicine*, 8(7), 1890-1902.
- Christensen, B. S., Grønbæk, M., Pedersen, B. V., Graugaard, C., & Frisch, M. (2011b). Associations of unhealthy lifestyle factors with sexual inactivity and sexual dysfunctions in Denmark. *The journal of sexual medicine*, 8(7), 1903-1916.
- Cindoglu, D., & Unal, D. (2017). Gender and sexuality in the authoritarian discursive strategies of 'New Türkiye'. *European Journal of Women's Studies*, 24(1), 39-54.
- Collins, K. M., & Levitt, H. M. (2021). Heterosexism and the self: a systematic review informing LGBTQ-affirmative research and psychotherapy. *Journal of Gay & Lesbian Social Services*, 33(3), 376-405.
- Collins, N.D.,(2025). Sexual orientation. In *Collins English Dictionary* online, [https://www.collinsdictionary.com/dictionary/english/sexualorientation#google\\_vignette](https://www.collinsdictionary.com/dictionary/english/sexualorientation#google_vignette)

- Cupit, R. W. (2010). Counselors' comfort levels and willingness to discuss sexual issues with couples they counsel (Doctoral dissertation). [Retrieved from ProQuest Dissertations and Theses database] (Order No. 3414807).
- Çayan, S., Kendirci, M., Yaman, Ö., Aşçı, R., Orhan, İ., Usta, M. F., ... & Kadioğlu, A. (2017). Prevalence of erectile dysfunction in men over 40 years of age in Türkiye: Results from the Turkish society of andrology male sexual health study group. *Turkish Journal Of Urology*, 43(2), 122.
- Çuhadaroğlu, A. (2017). The effects of sex education on psychological counselling students in Türkiye. *Sex Education*, 17(2), 209-219.
- D'Arrigo, T. (2021). Treating patients means talking about sex. *Psychiatric News*, 56(8). <https://doi.org/10.1176/appi.pn.2021.7.38>
- Darwin, C. (1872). The descent of man, and selection in relation to sex (Vol. 2). D. Appleton.
- Davey Smith, G. (1997). Sex and death: are they related? Findings from the Caerphilly Cohort Study. *BMJ: British Medical Journal*, 315, 1641.
- Davis, D., Shaver, P. R., & Vernon, M. L. (2004). Attachment style and subjective motivations for sex. *Personality And Social Psychology Bulletin*, 30(8), 1076-1090.
- Dekker, A., Matthiesen, S., Cerwenka, S., Otten, M., & Briken, P. (2020). Health, sexual activity, and sexual satisfaction: selected results from the German health and sexuality survey (gesid). *Deutsches Ärzteblatt International*, 117(39), 645.

- Dermer, S., & Bachenberg, M. (2015). The importance of training marital, couple, and family therapists in sexual health. *Australian and New Zealand Journal of Family Therapy*, 36(4), 492-503.
- Deutsch, A. R., Hoffman, L., & Wilcox, B. L. (2014). Sexual self-concept: testing a hypothetical model for men and women. *The Journal of Sex Research*, 51(8), 932-945.
- Diamond, L. M., & Huebner, D. M. (2012). Is good sex good for you? rethinking sexuality and health. *Social and Personality Psychology Compass*, 6(1), 54-69.
- Dogan, S. (2009). Vaginismus and accompanying sexual dysfunctions in a Turkish clinical sample. *The Journal Of Sexual Medicine*, 6(1), 184-192.
- Dogan, S., Demir, B., Eker, E., & Karim, S. (2008). Knowledge and attitudes of doctors toward the sexuality of older people in Türkiye. *International Psychogeriatrics*, 20(5), 1019-1027.
- Dogan, T., Tugut, N., & Golbasi, Z. (2013). The relationship between sexual quality of life, happiness, and satisfaction with life in married Turkish women. *Sexuality and Disability*, 31, 239-247.
- Edwards, J. N., & Booth, A. (1994). Sexuality, marriage, and well-being: The middle years. *The University of Chicago Press*.
- Ellis, H. (1910). Studies in the psychology of sex, volume I: The evolution of modesty, the phenomena of sexual periodicity, auto-erotism. *FA Davis Company*.
- Ellis, H. (1915). Studies in the psychology of sex, volume II: Sexual inversion (pp. 15-19). *London: Routledge*.

- Fallis, E. E., Rehman, U. S., Woody, E. Z., & Purdon, C. (2016). The longitudinal association of relationship satisfaction and sexual satisfaction in long-term relationships. *Journal of Family Psychology, 30*(7), 822–831.
- Farber, B. A., & Hall, D. (2002). Disclosure to therapists: what is and is not discussed in psychotherapy. *Journal Of Clinical Psychology, 58*(4), 359-370.
- Ford, M. P., & Hendrick, S. S. (2003). Therapists' sexual values for self and clients: implications for practice and training. *Professional Psychology: Research and Practice, 34*(1), 80.
- Freud, S. (1905). Three essays on the theory of sexuality. *Se, 7*, 125-243.
- Freud, S. (1989). The ego and the id (1923). *Tacd Journal, 17*(1), 5-22.
- Gonick, M., & Conrads, J. (2022). Gender, sexuality, adolescence, and identity in schooling. *In Oxford Research Encyclopedia of Education*.
- Güneş, M., Uyar, B., Şener, Z. T., & İnan, E. Ç. (2025). Evaluation of the level of belief in sexual myths of women with vaginismus and their partners. *Psychiatry and Behavioral Sciences, 15*(1), 16.
- Hackathorn, J. M., Ashdown, B. K., & Rife, S. C. (2016). The sacred bed: sex guilt mediates religiosity and satisfaction for unmarried people. *Sexuality & Culture, 20*, 153-172.
- Haldeman, D. C. (2010). Reflections of a gay male psychotherapist. *Psychotherapy: Theory, Research, Practice, Training, 47*(2), 177.
- Hanzlik, M. P., & Gaubatz, M. (2012). Clinical PsyD trainees' comfort discussing sexual issues with clients. *American Journal of Sexuality Education, 7*(3), 219-236.

- Hariri, A. G., Karadag, F., Gokalp, P., & Essizoglu, A. (2011). Risky sexual behavior among patients in Türkiye with bipolar disorder, schizophrenia, and heroin addiction. *The Journal Of Sexual Medicine*, 8(8), 2284-2291.
- Harris, S. M., & Hays, K. W. (2008). Family therapist comfort with and willingness to discuss client sexuality. *Journal of Marital and Family Therapy*, 34(2), 239–250.
- Heidari, M., Ghodusi, M., & Rafiei, H. (2017) Sexual self-concept and its relationship to depression, stress and anxiety in postmenopausal women. *J Menopausal Med.*, 23 (1): 42–8.
- Helminiak, D. A. (1989). Self-Esteem, Sexual self-acceptance, and spirituality. *Journal of Sex Education and Therapy*, 15(3), 200–210.
- Henderson-King, D. H., & Veroff, J. (1994). Sexual satisfaction and marital well-being in the first years of marriage. *Journal of Social and Personal Relationships*, 11(4), 509-534.
- Hendry, A., Snowden, A., & Brown, M. (2018). When holistic care is not holistic enough: the role of sexual health in mental health settings. *Journal Of Clinical Nursing*, 27(5-6), 1015-1027.
- Hensel, D.J., Fortenberry, J.D., O'Sullivan, L.F., Orr, D.P.(2011). The developmental association of sexual self-concept with sexual behavior among adolescent women. *The Journal of Adolescent Health*., (4):675-84.
- Hensel, D. J., Nance, J., & Fortenberry, J. D. (2016). The association between sexual health and physical, mental, and social health in adolescent women. *Journal of Adolescent Health*, 59(4), 416-421.

- Higgins, A. (2007). Impact of psychotropic medication on sexuality: literature review. *British Journal of Nursing, 16*(9), 545-550.
- Higgins, A., Barker, P., & Begley, C. M. (2005). Neuroleptic medication and sexuality: the forgotten aspect of education and care. *Journal Of Psychiatric And Mental Health Nursing, 12*(4), 439-446.
- Hocaoglu, C., Celik, F. H., Kandemir, G., Guveli, H., & Bahceci, B. (2014). Sexual dysfunction in outpatients with schizophrenia in Türkiye: a cross-sectional study. *Shanghai Archives of Psychiatry, 26*(6), 347.
- Impett, E. A., Muise, A., & Peragine, D. (2014). Sexuality in the context of relationships. In D. L. Tolman, L. M. Diamond, J. A. Bauermeister, W. H. George, J. G. Pfaus, & L. M. Ward (Eds.), *APA handbook of sexuality and psychology*, vol. 1. person-based approaches (pp. 269–315). *American Psychological Association*.
- Joe, J. R., Shillingford, M. A., Aaron, S., Pharaoh, T., & Gonner, J. (2023). Sexual health and HIV prevention for youth: a survey of school counselors' beliefs, attitudes, and professional behaviors. *Professional School Counseling, 27*(1), 2156759X231165494.
- Kennis, M., Duecker, F., T'Sjoen, G., Sack, A. T., & Dewitte, M. (2022). Sexual self-concept discrepancies mediate the relation between gender dysphoria sexual esteem and sexual attitudes in binary transgender individuals. *The Journal of Sex Research, 59*(4), 524-536.
- Kliesch, S. (2020). The connection between general and sexual health: the publication of the GeSiD study. *Deutsches Ärzteblatt International, 117*(39), 643.

- Kuhn, D., Nash, S. C., & Brucken, L. (1978). Sex role concepts of two- and three-year-olds. *Child Development*, 445-451.
- Larson, P. C. (1981). Sexual Identity and Self-Concept. *Journal of Homosexuality*, 7(1), 15-32. [https://doi.org/10.1300/J082v07n01\\_03](https://doi.org/10.1300/J082v07n01_03)
- Leavy, P., & Hastings, L. (2010). Body image and sexual identity: An interview study with lesbian, bisexual and heterosexual college age-women. *Electronic Journal of Human Sexuality*, 13(1).
- Little, K. C., McNulty, J. K., & Russell, V. M. (2010). Sex buffers intimates against the negative implications of attachment insecurity. *Personality and Social Psychology Bulletin*, 36(4), 484-498.
- Love, M., & Farber, B. A. (2017). Let's not talk about sex. *Journal of Clinical Psychology*, 73(11), 1489-1498
- Loveless, C. A., & Quinn-Nilas, C. (2024). A study of the dyadic associations of self-compassion on sexual satisfaction and dissatisfaction: evidence of differential associations. *The Journal of Sex Research*, 1-13.
- Lund, J. I., Kleinplatz, P. J., Charest, M., & Huber, J. D. (2019). The relationship between the sexual self and the experience of pregnancy. *The Journal of Perinatal Education*, 28(1), 43-50.
- Magaldi-Dopman, D., Park-Taylor, J., & Ponterotto, J. G. (2011). Psychotherapists' spiritual, religious, atheist or agnostic identity and their practice of psychotherapy: a grounded theory study. *Psychotherapy Research*, 21(3), 286-303.

- Manickam, L. S. S. (2019). Has the Kama Sutra not made a difference? Making psychologists in India explore sexual functioning and master sex therapy. *Journal of Psychosexual Health, 1*(3-4), 211-214.
- Markovic, D. (2007). Working with sexual issues in systemic therapy. *Australian and New Zealand Journal Of Family Therapy, 28*(4), 200-209.
- Martin, K. (2018). Puberty, sexuality and the self: Girls and boys at adolescence. *Routledge*. <https://doi.org/10.4324/9781315538853>
- McClure, L. (2012). Where is the sex in mental health practice? a discussion of sexuality care needs of mental health clients. *Journal of Ethics in Mental Health*.
- McGrath, M., & Lynch, E. (2014). Occupational therapists' perspectives on addressing sexual concerns of older adults in the context of rehabilitation. *Disability and Rehabilitation, 36*(8), 651-657.
- Meston, C. M., & Buss, D. M. (2007). Why humans have sex. *Archives Of Sexual Behavior, 36*, 477-507.
- Miller, S. A., & Byers, E. S. (2010). Psychologists' sexual education and training in graduate school. *Canadian Journal Of Behavioural Science/Revue Canadienne Des Sciences Du Comportement, 42*(2), 93.
- Milton, J., Berne, L., Patton, W., & Peppard, J. (2001). School counsellors' role in sexuality education: What messages about sexual behaviour and sexual responsibility do they give Australian students?. *Journal of Psychologists and Counsellors in Schools, 11*, 35-50.
- Montejo, A. L. (2019). Sexuality and mental health: the need for mutual development and research. *Journal Of Clinical Medicine, 8*(11), 1794.

- Moore, B. J. (2018). Therapists' attitudes, knowledge, comfort, and willingness to discuss sexual topics with clients. *Walden University*.
- Nabila, T. N., & Larue, C. D. N. (2023). A quantitative study of intimate partner violence context: is self-compassion related to sexual esteem?. *Developmental and Clinical Psychology, 4*(1), 11-19.
- Naughton, T. (2022). "talk about sex?": therapists' experience of facilitating discussion of the topics of gender and sexuality in therapy. *European Journal of Psychotherapy & Counselling, 24*(4), 402-418.
- Northcott, R., & Chard, G. (2000). Sexual aspects of rehabilitation: The client's perspective. *British Journal of Occupational Therapy, 63*(9), 412-418.
- Oner, S., Yenilmez, C., & Ozdamar, K. (2015). Sex-related differences in methods of and reasons for suicide in Türkiye between 1990 and 2010. *Journal Of International Medical Research, 43*(4), 483-493.
- Ozan, S., Aras, S., Semin, S., & Orcin, E. (2005). Sexual attitudes and behaviors among medical students in Dokuz Eylul University, Türkiye. *The European Journal of Contraception & Reproductive Health Care, 10*(3), 171-183.
- Ozkan, B., Orhan, E., Aktas, N., & Coskuner, E. R. (2015). Depression and sexual dysfunction in Turkish men diagnosed with infertility. *Urology, 85*(6), 1389-1393.
- Ören, B., Zengin, N., Yazıcı, S., & Akıncı, A. Ç. (2018). Attitudes, beliefs and comfort levels of midwifery students regarding sexual counselling in Türkiye. *Midwifery, 56*, 152-157.

- Özcan, N. K., Boyacıoğlu, N. E., Enginkaya, S., Dinç, H., & Bilgin, H. (2014). Reproductive health in women with serious mental illnesses. *Journal Of Clinical Nursing*, 23(9-10), 1283-1291.
- Polat, A., Yuksel, S., Discigil, A. G., & Meteris, H. (2005). Family attitudes toward transgendered people in Türkiye: Experience from a secular Islamic country. *The International Journal of Psychiatry in Medicine*, 35(4), 383-393.
- Potki, R., Ziaei, T., Faramarzi, M., Moosazadeh, M., & Shahhosseini, Z. (2017). Bio-psycho-social factors affecting sexual self-concept: A systematic review. *Electronic Physician*, 9(9), 5172.
- Quinn, C., & Browne, G. (2009). Sexuality of people living with a mental illness: a collaborative challenge for mental health nurses. *International Journal of Mental Health Nursing*, 18(3), 195-203.
- Quinn, C., Happell, B., & Browne, G. (2011). Talking or avoiding? mental health nurses' views about discussing sexual health with consumers. *International Journal of Mental Health Nursing*, 20(1), 21-28.
- Quinn, C., Happell, B., & Browne, G. (2011). Talking or avoiding? mental health nurses' views about discussing sexual health with consumers. *International Journal of Mental Health Nursing*, 20(1), 21-28.
- Quinn-Nilas, C. (2020). Relationship and sexual satisfaction: a developmental perspective on bidirectionality. *Journal of Social and Personal Relationships*, 37(2), 624-646.
- Quiñones, T. J., Woodward, E. N., & Pantalone, D. W. (2017). Sexual minority reflections on their psychotherapy experiences. *Psychotherapy Research*, 27(2), 189-200.

- Reissing, E. D., & Giulio, G. D. (2010). Practicing clinical psychologists' provision of sexual health care services. *Professional Psychology: Research and Practice*, 41(1), 57–63. <https://doi.org/10.1037/a0017023>
- Ridley, J. (2006). The subjectivity of the clinician in psychosexual therapy training. *Sexual and Relationship Therapy*, 21(3), 319-331.
- Robinson, P. A. (1973). Havelock Ellis and modern sexual theory. *Salmagundi*, (21), 27-62.
- Sakaluk, J. K., Kim, J., Campbell, E., Baxter, A., & Impett, E. A. (2020). Self-esteem and sexual health: a multilevel meta-analytic review. *Health Psychology Review*, 14(2), 269-293.
- Satcher, D. (2001). The surgeon general's call to action to promote sexual health and responsible sexual behavior. *Washington, DC: U.S. Department of Health and Human Services*.
- Seitz, T., Ucsnik, L., Kottmel, A., Bitzer, J., Teleky, B., & Löffler-Stastka, H. (2020). Let us integrate sexual health—do psychiatrists integrate sexual health in patient management?. *Archives of Women's Mental Health*, 23, 527-534.
- Shafir, N., & Balahur, D. (2022). Influence of a group supervision program in sex therapy on therapists' self-efficacy and attitudes toward sexuality. *Psychology*, 13(12), 1765-1795.
- Shaver, P., & Hazan, C. (1987). Being lonely, falling in love. *Journal of Social Behavior and Personality*, 2(2), 105.

- Shaw, E., Butler, C. A., & Marriott, C. (2008, July). Sex and sexuality teaching in UK clinical psychology courses. *Clinical Psychology Forum* (Vol. 187, pp. 7-11). British Psychological Society.
- Simpson, S. A., & McDowell, A. K. (2019). Be honest about your limitations: relieve yourself of unobtainable expectations and reset the conflictual encounter. in the clinical interview (pp. 56-58). *Routledge*.
- Sprecher, S. (2002). Sexual satisfaction in premarital relationships: associations with satisfaction, love, commitment, and stability. *Journal Of Sex Research*, 39(3), 190-196.
- Sümer, Z. H. (2015). Gender, religiosity, sexual activity, sexual knowledge, and attitudes toward controversial aspects of sexuality. *Journal Of Religion And Health*, 54, 2033-2044.
- Talley, A. E., Brown, S. L., Cukrowicz, K., & Bagge, C. L. (2016). Sexual self-concept ambiguity and the interpersonal theory of suicide risk. *Suicide and Life-Threatening Behavior*, 46(2), 127-140.
- Temple-Smith, M., Moore, S., & Rosenthal, D. (2018). Sexuality in adolescence: The digital generation (1st ed.). *Routledge*.
- Thompson, S. K. (1975). Gender labels and early sex role development. *Child Development*, 339-347.
- Timm, T. M. (2009). "Do I really have to talk about sex?" encouraging beginning therapists to integrate sexuality into couples therapy. *Journal of Couple & Relationship Therapy*, 8(1), 15-33.

- Træen, B., & Schaller, S. (2013). Talking to patients about sexual issues: experiences of Norwegian psychologists. *Sexual and Relationship Therapy, 28*(3), 281-291.
- Turan, S., Poyraz, C. A., Emül, H. M., & Duran, A. (2015). Sociodemographic and clinical characteristics of transsexual individuals who applied to a psychiatry clinic for sex reassignment surgery. *Turk Psikiyatri Dergisi, 26*(3), 153.
- Urry, K., Breakey, G. R., Scholz, B., & Chur-Hansen, A. (2024). Approaches for improving sexuality and sexual health care in mental health settings: a qualitative study exploring clinicians' own perspectives. *International Journal of Mental Health Nursing, 33*(1), 125-133.
- Urry, K., Chur-Hansen, A., & Khaw, C. (2019). 'It's just a peripheral issue': a qualitative analysis of mental health clinicians' accounts of (not) addressing sexuality in their work. *International Journal of Mental Health Nursing, 28*(6), 1278-1287.
- Ünal Toprak, F., & Turan, Z. (2021). The effect of sexual health courses on the level of nursing students' sexual/reproductive health knowledge and sexual myths beliefs in Türkiye: a pretest-posttest control group design. *Perspectives in Psychiatric Care, 57*(2), 667-674.
- Ünsal, B. C., & Bozo, Ö. (2023). Minority stress and mental health of gay men in Türkiye: The mediator roles of shame and forgiveness of self. *Journal of Homosexuality, 70*(8), 1503-1520.
- Vasilenko, S. A., & Lefkowitz, E. S. (2018). Sexual behavior and daily affect in emerging adulthood. *Emerging Adulthood, 6*(3), 191-199.
- Vasilenko, S. A., Lefkowitz, E. S., & Welsh, D. P. (2014). Is sexual behavior healthy for adolescents? A conceptual framework for research on adolescent sexual

behavior and physical, mental, and social health. *New Directions For Child And Adolescent Development*, 2014(144), 3-19.

Webb, H. J., Zimmer-Gembeck, M. J., Mastro, S., Farrell, L. J., Waters, A. M., & Lavell, C. H. (2015). Young adolescents' body dysmorphic symptoms: associations with same-and cross-sex peer teasing via appearance-based rejection sensitivity. *Journal of Abnormal Child Psychology*, 43, 1161-1173.

Weinraub, M., Clemens, L. P., Sockloff, A., Ethridge, T., Gracely, E., & Myers, B. (1984). The development of sex role stereotypes in the third year: relationships to gender labeling, gender identity, sex-types toy preference, and family characteristics. *Child Development*, 1493-1503.

White, D., & Stephenson, R. (2014). Identity formation, outness, and sexual risk among gay and bisexual men. *American Journal Of Men's Health*, 8(2), 98-109.

Yasan, A., & Gürgen, F. (2008). Marital satisfaction, sexual problems, and the possible difficulties on sex therapy in traditional Islamic culture. *Journal Of Sex & Marital Therapy*, 35(1), 68-75.

Yildirimer, K. S., & Yentür, B. (2024). Sexual health and psychological well-being: An examination of the interactions between sexual satisfaction, relationship dynamics, and mental health. *International Journal of Social Science and Human Research*, 7(10). <https://doi.org/10.47191/ijsshr/v7-i10-18>

Yilmaz, V., & Willis, P. (2020). Challenges to a rights-based approach in sexual health policy: a comparative study of Türkiye and England. *Societies*, 10(2), 33.

Young, K., Dodington, A., Smith, C., & Heck, C. S. (2020). Addressing clients' sexual health in occupational therapy practice. *Canadian Journal of Occupational Therapy*, 87(1), 52-62.

- Yüksel, Ş., Kulaksizoğlu, I. B., Türksoy, N., & Şahin, D. (2000). Group psychotherapy with female-to-male transsexuals in Türkiye. *Archives of Sexual Behavior*, 29, 279-290.
- Zhang, X., Sherman, L., & Foster, M. (2020). Patients' and providers' perspectives on sexual health discussion in the United States: a scoping review. *Patient education and counseling*, 103(11), 2205-2213.
- Zengin, A. (2014). Sex for law, sex for psychiatry: pre-sex reassignment surgical psychotherapy in Türkiye. *Anthropologica*, 55-68.

## **APPENDICES**

### **Appendix A. Result of the Evaluation by the Ethics Committee**

Ethics Board Approval is available in the printed version of this dissertation.

## Appendix B. Consent Form

### Bilgilendirilmiş Onam Formu (Online Anket)

<b>Araştırmayı Destekleyen Kurum:</b>	İstanbul Bilgi Üniversitesi
<b>Araştırmanın Adı:</b>	Türkiye’deki Terapistler Arasında Cinsellik Konuşma Eğilimleri: Bir Keşif Çalışması
<b>Araştırmacının Adı:</b>	Betül Buzluk
<b>Araştırmacının E-mail Adresi ve Telefonu:</b>	
<b>Araştırmanın Danışmanı:</b>	Dr. Öğr. Üyesi Taner Yılmaz
<b>Danışmanın E-mail Adresi ve Telefonu:</b>	

Bu çalışma Bilgi Üniversitesi Klinik Psikoloji Yüksek Lisans Programı öğrencisi Psikolog Betül Buzluk tarafından Dr. Öğretim Üyesi Taner Yılmaz danışmanlığında yüksek lisans tezi kapsamında yürütülmektedir. Bu çalışma, Türkiye’deki psikoterapistlerin terapide cinsellik konuşmaya dair eğilimlerini keşfetmek amacıyla yapılmaktadır. Çalışmanın bulguları ile terapilerde cinsellik çalışmak üzerine mevcut durumun anlaşılması ve alanda çalışan uzmanların ve eğitmenlerin bu hususta bilgilendirilmesi amaçlanmaktadır.

Bu çalışma kapsamında ilk olarak katılımcılardan kısa bir bilgi formu doldurması, daha sonra yaklaşık 15 dakika sürecek bir anket cevaplama istenecektir.

Bu araştırma bilimsel bir amaçla yapılmaktadır ve katılımcı bilgilerinin gizliliği esastır. Formlara verdiğiniz cevaplar kaydedilirken isminiz sorulmayacak ve kişisel bilgileriniz kaydedilmeyecektir. Bu bilgiler yalnızca araştırmacının ve tez danışmanının erişimi olan şifreli bir dosyada ve şifreli bir bilgisayarda tutulacak, anonim veri saklama

yükümlülüğüne bağlı olarak 5 yıl boyunca dışarıdan erişime kapalı olarak muhafaza edilecektir.

Bu çalışmaya katılmak tamamen isteğe bağlıdır. Çalışma ve anket soruları tetikleyici özellik taşımamakta olup katılımcılarda bir zorlanma ya da zarara yol açması beklenmemektedir. Çalışmaya katılmanın üzerinizde herhangi bir olumsuz etki yaratmayacağı öngörülmektedir. Katılmayı kabul ettiğiniz takdirde çalışmanın herhangi bir aşamasında onayınızı geri alma ve çalışmadan ayrılma hakkına sahipsiniz. Çalışmayı yarım bıraktığınız durumda verdiğiniz bilgiler araştırmaya dahil edilmeyecektir.

Araştırmayla ilgili bilgi almak, soru sormak veya yorumlarınızı paylaşmak isterseniz, araştırmacı Betül Buzluk ile eposta adresinden iletişime geçebilirsiniz.

Eğer araştırmaya katılmaya onay veriyorsanız, aşağıdaki bölümdeki madde için “Evet” seçeneğini işaretlemeniz yeterlidir.

Bu çalışmaya tamamen gönüllü olarak katılıyorum. Bana anlatılanları ve yukarıdaki açıklamaları anladım. Çalışmaya katılmayı ve verdiğim bilgilerin bilimsel amaçlı yayın, rapor ve sunumlarda kullanılmasını kabul ediyorum.

## Appendix C. Demographic Questions

Aşağıdaki demografik soruları cevaplayınız.

Cinsiyet: .....

Yaş: .....

Cinsel yönelim: .....

Kaç yıldır terapi yapıldığı: .....

Uzmanlık: (Sizi uyan tüm şıkları işaretleyiniz: Yetişkin, Çift / Aile, Çocuk / Ergen)

Aşağıdaki soruları cevaplayınız. (1 = kesinlikle katılmıyorum, 6 = kesinlikle katılıyorum)

1. Cinselliği konuşmaya açık bir ailede büyüdüm.
2. Kültürüme göre kişinin cinsel hayatıyla ilgili konuları ötekine açması doğru değildir.

## Appendix D. Clinical Training Scales (Education, Supervision, Experience)

### 1. Lisansüstü seviyede cinsellik eğitimi (Size uyan tüm şıkları işaretleyiniz.)

- A. Lisansüstü seviyede cinsellikle ilgili hiçbir ders almadım.
- B. Lisansüstü seviye bir dersin belli bir kısmında cinsellik üzerine eğitim aldım.
- C. Lisansüstü seviyede cinsellik üzerine bir ders aldım.
- D. Cinsellik konuları lisansüstü ders programıma entegre edilmişti.
- E. Cinsellikle ilgili atölyelere/kısa eğitimlere katıldım.
- F. Cinsellik üzerine 4 oturumdan uzun bir eğitim aldım.
- G. Cinsellik üzerine aktif olarak okumalar yapar, alanda güncel kalırım.
- H. Cinsellik üzerine lisansüstü seviyede eğitim verdim.

### 2. Cinsellikle ilgili konular üzerine süpervizyon deneyimi (Size uyan tüm şıkları işaretleyiniz.)

- A. Cinsellikle ilgili konular üzerine bir süpervizörle hiç konuşmadım.
- B. Cinsellikle ilgili konular üzerine en az 1 defa süpervizyon aldım.
- C. Cinsellikle ilgili konular üzerine zaman zaman süpervizyon aldım.
- D. Lisansüstü eğitimim sırasında cinsellikle ilgili konular üzerine süpervizyon aldım.
- E. Cinsellikle ilgili konular üzerine düzenli olarak süpervizyon aldım.
- F. Danışanlarımın cinsel meseleleriyle ilgili meslektaşlarıma danıştım.

### 3. Cinsellikle ilgili konular üzerine klinik deneyim (Size uyan tüm şıkları işaretleyiniz.)

- A. Cinsellikle ilgili konular üzerine hiç klinik deneyimim olmadı.
- B. Cinsellikle ilgili konular üzerine çalıştığım en az bir vaka oldu.
- C. Cinsellikle ilgili konular üzerine zaman zaman danışanlarla çalışırım.
- D. Cinsellikle ilgili konular üzerine düzenli olarak danışanlarla çalışırım.
- E. Cinsellikle ilgili konular üzerine çalışmaya adanmış bir staj deneyimim oldu.

## Appendix E. Sexual Discussions Scale

1. Aşağıdaki soruları cevaplayınız. (1 = kesinlikle katılmıyorum, 6 = kesinlikle katılıyorum)

- A. Terapi süreçlerimde cinsellik üzerine konuşuruz.
- B. Terapi süreçlerimde her danışanla cinsellik üzerine konuşuruz.
- C. Terapi süreçlerimde cinsellik konularını en az diğer konular kadar sık konuşuruz.
- D. Cinsellikle ilgili konularda ancak danışan bir sorunu/kaygısı olduğunu ifade ettiğinde değerlendirme yapar ve sohbetler başlatırım.

2. Şu konularda değerlendirme yapar ve terapötik sohbet başlatırım: (1 = hiçbir zaman, 6 = her zaman)

- A. cinsel gelişim hikayesi
- B. cinsel yönelim
- C. danışanın cinsel hayatıyla ilgili memnuniyeti
- D. danışanın tipik cinsel ilişkilene paterni
- E. cinsel istismar
- F. korunma ve üreme

## Appendix F. The Turkish Version of the Snell-Papini Sexuality Scale

Aşağıdaki ifadelerin sizin için ne kadar uygun olduğunu seçiniz. (1 = kesinlikle katılmıyorum, 5 = kesinlikle katılıyorum)

1. Ben iyi bir cinsel partnerim.
2. Cinselliğim hakkında karamsar ve depresifim.
3. Sürekli cinselliği düşünürüm.
4. Cinsel becerilerimi oldukça iyi bulurum.
5. Cinsel yaşamımın kalitesi beni hayal kırıklığına uğrattıyor.
6. Cinselliği herhangi bir şeyden daha çok düşünürüm.
7. Cinsellikte birçok kişiden daha iyiyim.
8. Cinsel yaşamımla ilgili olarak kendimi kötü hissediyorum.
9. Cinsellik hakkında aşırı düşünmek eğilimindeyim.
10. Cinsel yeterliliğim hakkında bazen şüphelerim olur.
11. Cinsellikle ilgili ilişkilerim konusunda kendimi mutsuz hissediyorum.
12. Sürekli olarak cinsel ilişkide bulunma konusunda düşünüyorum.
13. Cinsellikle karşı karşıya kaldığımda kendime pek güvenemem.
14. Cinsel deneyimlerimi düşündüğümde üzülürüm.
15. Cinselliği düşünmek için epeyce zaman harcarım.
16. Çok iyi bir cinsel partner olduğumu düşünüyorum.
17. Bir cinsel partner olarak kendime düşük puan verirdim.
18. Cinsel partner olarak kendimden eminim.
19. Cinsel becerilerim konusunda kendime çok güvenmem.
20. Bazen cinsel yeterliliğimle ilgili olarak ikilem yaşarım.

## Appendix G. Exploratory Items

Aşağıdaki soruları cevaplayınız. (1 = kesinlikle katılmıyorum, 6 = kesinlikle katılıyorum)

1. Bir danışanın cinsellikle ilgili bir endişesi/konusu varsa, onu başka bir uzmana yönlendirmek en iyisi olur diye düşünürüm.
2. Cinsel sorunları olan danışanlarla çalışmamayı tercih ederim.
3. Terapilerde cinsellik konuşmak yararlı ve gereklidir.
4. Danışanın temel problemi cinsellikle bağlantılı değilse cinsellik konuşmaya gerek yok diye düşünürüm.
5. Danışanım cinsellikle ilgili konuşmaya başladığında telaşlanırım.
6. Danışanım cinsel hayatını ve yaşantılarını anlatırken rahatsız hissedirim.
7. Danışanlarımla cinsel sorunları ve endişeleri üzerine çalışmakta rahat hissedirim.
8. Cinsellikle ilgili konularda gerektiğinde danışana doğru bilgiler aktarabileceğime inanıyorum.
9. Seanslarımda cinsellikle ilgili konuları ele alış miktarımı yeterli buluyorum.
10. Terapilerde cinsellik konularını ele alacak genel yetkinliğim vardır.
11. Benimle aynı cinsiyette danışanlarla cinsellik konuşmak daha kolaydır.
12. Yaşı bana yakın danışanlarla cinsellik konuşmak daha kolaydır.
13. Aynı cinsel yönelimde olduğum danışanlarla cinsellik konuşmak daha kolaydır.

## **Appendix H. Permission by Steven Harris for the use of Clinical Training Scales**

The permission by Steven Harris for the use of his measures is available in the printed version of this dissertation.