Attitudes toward seeking help for sexual dysfunctions among US and Swedish college students

Linnea Bergvall & Melissa J. Himelein

* Department of Psychology, University of North Carolina at Asheville, Asheville, NC, USA

Published online: 28 Nov 2013.

To cite this article: Linnea Bergvall & Melissa J. Himelein, Sexual and Relationship Therapy (2013): Attitudes toward seeking help for sexual dysfunctions among US and Swedish college students, Sexual and Relationship Therapy, DOI: [10.1080/14681994.2013.860222](http://dx.doi.org/10.1080/14681994.2013.860222)

To link to this article: [http://dx.doi.org/10.1080/14681994.2013.860222](http://dx.doi.org/10.1080/14681994.2013.860222)
Attitudes toward seeking help for sexual dysfunctions among US and Swedish college students

Linnea Bergvall and Melissa J. Himelein*

Department of Psychology, University of North Carolina at Asheville, Asheville, NC, USA

(Received 24 May 2013; accepted 22 October 2013)

The present study examined help-seeking attitudes and stigma related to sexual problems, issues largely neglected by previous researchers. In addition, the impact of sociocultural variables on attitudes was explored. College students at public universities in the United States (n = 78) and Sweden (n = 81) completed three scales of stigma and help-seeking and rated the likelihood that they would seek help for sexual problems from each of five types of professionals. Despite differing cultural perspectives, participants from the two samples were more alike than different. In both countries, respondents expressed moderate-to-high willingness to seek help for sexual problems and low-to-moderate levels of stigma; openness to help-seeking was inversely related to stigma. Males reported higher self-stigma than females, and students who identified as Christian reported greater stigma than non-religious students. Participants reported that they would be most likely to seek help for sexual problems from gynecologists/urologists and family physicians, followed in order by sex therapists, psychologists, and counselors. Implications of these findings include consideration of self-stigma as a barrier to seeking treatment, differences in help-seeking attitudes for mental health vs. sexual concerns, and the need for greater understanding about accessing treatment for sexual dysfunctions.

Keywords: stigma; self-stigma; help-seeking; openness to seeking treatment; cross-cultural; sex therapy

Introduction

Worldwide, the prevalence of sexual dysfunctions is substantial. Epidemiological studies indicate that sexual problems are typically reported by 25%–30% of males and 40%–45% of females, though rates of most dysfunctions are lower in younger than in older adults (DeRogatis & Burnett, 2008; Lewis et al., 2010). However, the vast majority of individuals experiencing sexual problems do not seek treatment (Moreira et al., 2005), even when their difficulties cause distress (Shifren et al., 2009). The present study seeks to explore possible factors that prevent people from seeking professional help for sexual dysfunctions.

One variable that may play a role in the decision to pursue treatment for sexual problems is the perception of stigma, which has been shown to deter individuals with mental health problems from seeking treatment (for reviews, see Schomerus & Angermeyer, 2008; Shrivastava, Johnston, & Bureau, 2012). For example, negative perceptions of mental illness among patients with depression and schizophrenia have been shown not only to lessen treatment adherence (Fung, Tsang, & Corrigan, 2008; Interian et al., 2010), but also to deter individuals from seeking initial consultation (Eisenberg, Downs,
Golberstein, & Zivin, 2009). As conceptualized by Corrigan (2004), two types of stigma affect help-seeking for psychological problems. First, individuals may be concerned about the potentially negative perceptions of others were they to seek treatment (public stigma). Second, if people struggling with mental health difficulties have internalized adverse societal perceptions, they may avoid pursuing treatment because to do so would negatively affect personal self-esteem (self-stigma).

While researchers have not yet directly studied the impact of public stigma or self-stigma on seeking help for sexual problems, examination of qualitative data from investigations of related issues suggests that stigma may play a role in individuals’ decisions to seek, or not to seek, treatment. For example, Gott and Hinchliff (2003) interviewed older British adults, aged 50–92, regarding sexual health and attitudes toward treatment for sexual difficulties. Only 24% of participants who had experienced sexual problems had sought treatment. Personal embarrassment/shame was one of the six barriers to treatment described by participants, a response suggestive of self-stigma. Similarly, in an investigation of middle-aged and older adults with sexual dysfunctions in five Anglophone countries, only 32% had pursued medical treatment; embarrassment was the third most frequent reason cited for not seeking help, listed by 23% of the nonconsulters (Nicolosi et al., 2006). Adegunloye and Ezeoke (2011) surveyed Nigerian schoolteachers ranging in age from 20 to 65 years regarding sexual dysfunctions and help-seeking behavior. Among the 53% who reported a sexual dysfunction but did not seek treatment, “fear of stigma” was the reason provided by 26%. Finally, an international investigation of men of all ages with erectile dysfunction revealed that 33% felt that speaking to someone face-to-face about erections would be “impossible for me,” perhaps an indication of stigma. Country-specific percentages ranged from a low of 23% (US) to a high of 47% (France; Perelman, Shabsigh, Seftel, Althof, & Lockhart, 2005).

In addition to stigma, other factors likely affect the decision to seek treatment for sexual issues. Again drawing from the literature on help-seeking for psychological issues, researchers have shown that attitudes toward mental health treatment are influenced by sociodemographic variables, including gender, religion, and cultural background. Women have generally been found to have more positive attitudes about seeking psychological help than men, particularly in college samples (e.g., Elhai, Schweinle, & Anderson, 2008; Nam et al., 2010). While the impact of religious faith on overall help-seeking behavior is unclear, religiosity is associated with stronger preferences for help-seeking from a religious advisor, as opposed to a secular therapist, among both college students (Crosby & Bossley, 2012) and older adults (McGowan & Midlarsky, 2012). Religiosity may negatively influence the likelihood of seeking secular treatment if religious individuals experience greater personal stigma, as was the case among religious college students in Eisenberg et al.’s (2009) diverse, national sample. Regarding cultural background, several studies have pointed to the importance of background, ethnicity, or nationality on seeking help for psychological problems. Nam et al. (2010) found that among US college students, White students held more positive attitudes toward seeking help for psychological problems than Asian or Asian-American students. Within Western cultures, variability in attitudes is also evident. For example, an examination of individuals in 27 European nations revealed substantial differences across countries in both perceptions of individuals with mental health problems as well as actual help-seeking for psychological problems (European Commission, 2010).

Sociodemographic variables may also influence the decision to seek help for sexual dysfunctions. For example, gender comparisons were reported by Moreira et al. (2005), in their study of middle-aged and older adults in 29 countries. Although, across all
countries studied, similar proportions of men and women sought medical treatment for sexual dysfunctions (18% vs. 18.8%), substantial gender differences were revealed within particular geographic regions. The researchers noted the importance of considering cultural and religious differences in explaining help-seeking behavior, with gender likely interacting with both the variables. Few other investigations, to our knowledge, have assessed the impact of these factors on the decision to seek treatment for sexual problems.

One additional issue that may affect help-seeking for sexual problems is knowledge about, and access to, appropriate professional services. A lack of information about treatment was perceived as a deterrent to seeking help among participants in two qualitative studies, both conducted in England (Fitter, Hayter, & Wylie, 2009; Gott & Hinchliff, 2003). In each, interviewees described their desire for more knowledge of treatment options. While primary care professionals would seem an obvious source of such information, they may be reluctant to raise the topic of sexual concerns (Gott, Galena, Hinchliff, & Elford, 2004), leaving patients to find resources on their own. Because treatment for sexual dysfunctions is provided by different types of practitioners, including sex therapists, psychologists, counselors, and medical personnel (Moreira et al., 2005), prospective patients may be understandably confused by available alternatives. Navigating these options may make seeking help for sexual problems even more confusing than seeking help for psychological problems (see Vogel, Wade, & Haake, 2006).

The present study examined attitudes toward help-seeking for sexual problems in the context of three potentially influential variables. First, does stigma play a role in the decision to seek professional treatment for sexual dysfunctions? We assessed self-stigma as well as a particular type of public stigma defined by Vogel, Wade, and Ascheman (2009): stigma by one’s social network, or the perception of stigma from acquaintances, friends, and family.

Second, to what extent are sociodemographic factors related to help-seeking for sexual problems? Following the research on help-seeking for psychological issues, we focused on three such variables: gender, religion, and nationality. Related to the latter, we compared participants from two Western nations, Sweden and the US. While similar in some respects, the two countries also differ in important ways that may relate to this investigation. For example, Sweden provides health insurance for every citizen (Edgardh, 2002), with the goal of universal access to health care (Shea et al., 2003). This availability of affordable health care may encourage greater comfort and familiarity with varied services, including treatment for sexual dysfunctions. In addition, sexuality education has been required in Swedish schools since the 1950s, beginning in the early teenage years, and includes information about birth control, sexual anatomy, sexually transmitted illnesses, gender, and relationships (Edgardh, 2002; Parker, Wellings, & Lazarus, 2009). In contrast, sexuality education policies in the US vary from state to state, and many states favor programs focused on abstinence until marriage (Weaver, Smith, & Kippax, 2005). Swedish students have been found to have more permissive sexual attitudes and be more accepting of a variety of sexual behaviors than US students (Weinberg, Lottes, & Shaver, 2000). Further, levels of religiosity, which may affect help-seeking, are substantially higher in the US than in Sweden: 65% of Americans (vs. 17% of Swedes) report that religion is an important part of their lives (Crabtree & Pelham, 2009).

Third, we examined participants’ preferences regarding different types of helping professionals who treat individuals with sexual dysfunctions. What specialists are believed to be appropriate sources of treatment for sexual problems, and is there a preference toward help-seeking from medical or psychological professionals?
Methods

Participants

Participants were 159 college students from two universities: a small, public university in the southeastern US (n = 78) and a midsized public university in the western region of Sweden (n = 81). While the two groups were similar on most variables, the Swedish sample was significantly older than the US sample (M = 23.3 vs. 20.2, t [157] = 4.10, p < .001). Demographic characteristics of each sample are summarized in Table 1.

Measures

Openness to seeking help

To assess openness to seeking treatment for sexual problems, we adapted the 10-item Attitudes toward Seeking Professional Psychological Help Scale – Short Form (ATSPPH-SF; Fischer & Farina, 1995). The ATSPPH-SF is divided into two factors: “openness to seeking treatment for emotional problems” and “value and need in seeking treatment” (Elhai et al., 2008, p. 323). Only questions from the first factor were included in the adapted version. Scale instructions and questions were modified as follows: language referring to psychotherapy or psychological treatment was replaced with wording referring to “professional” help or treatment, and language referring to psychological distress was replaced with the phrase “a sexual problem.” For instance, “If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy” was changed to “If I were experiencing a serious sexual problem at this point in my life, I would be confident that I could find relief by obtaining help from a professional.” The modified version consisted of four statements, measured on a 4-point Likert scale (1 = disagree, 4 = agree); higher scores indicated greater

Table 1. Participant characteristics.

<table>
<thead>
<tr>
<th>Sociodemographic variables</th>
<th>US</th>
<th>Sweden</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>46%</td>
<td>43%</td>
<td>45%</td>
</tr>
<tr>
<td>Female</td>
<td>54%</td>
<td>57%</td>
<td>55%</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>91%</td>
<td>85%</td>
<td>88%</td>
</tr>
<tr>
<td>Other</td>
<td>9%</td>
<td>15%</td>
<td>12%</td>
</tr>
<tr>
<td>Relationship status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unmarried</td>
<td>85%</td>
<td>73%</td>
<td>79%</td>
</tr>
<tr>
<td>Married/cohabiting</td>
<td>15%</td>
<td>27%</td>
<td>21%</td>
</tr>
<tr>
<td>Religious affiliation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Christian</td>
<td>40%</td>
<td>36%</td>
<td>38%</td>
</tr>
<tr>
<td>Atheist/agnostic/none</td>
<td>54%</td>
<td>59%</td>
<td>57%</td>
</tr>
<tr>
<td>Other</td>
<td>6%</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Hometown population</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;20,000</td>
<td>27%</td>
<td>14%</td>
<td>21%</td>
</tr>
<tr>
<td>20,000–100,000</td>
<td>52%</td>
<td>70%</td>
<td>61%</td>
</tr>
<tr>
<td>100,000–250,000</td>
<td>10%</td>
<td>8%</td>
<td>9%</td>
</tr>
</tbody>
</table>
openness to seeking treatment. Elhai et al. (2008) reported ATSPPH-SF internal consistency of 0.77 with a college student sample; the modified version produced slightly lower internal consistency ($\alpha = 0.69$).

Self-stigma

To measure self-stigma toward seeking professional help for a sexual problem, we modified the 10-item Self-Stigma of Seeking Help Scale (SSOSH; Vogel et al., 2006). The two items from each of the scale’s two sections (nonreverse-keyed items and reverse-keyed items) that had the highest correlation with the total score were included in the adapted instrument. Each item was modified according to the aforementioned guidelines. For instance, “I would feel inadequate if I went to a therapist for psychological help” was changed to “I would feel inadequate if I went to a professional for help with a sexual problem.” Because embarrassment was identified by previous researchers as a barrier to seeking treatment for sexual problems (e.g., Nicolosi et al., 2006), we added one additional item to the adapted scale: “It would make me feel embarrassed to ask a professional for help with a sexual problem.” Each of the five questions was assessed on a 5-point Likert scale (1 = strongly disagree, 5 = strongly agree), with higher scores representing greater self-stigma. We obtained high internal consistency ($\alpha = 0.81$) with the modified scale, though slightly below the levels of 0.88–0.91 achieved in studies of the SSOSH with college student samples (Vogel et al., 2006).

Stigma by social network (social stigma)

Perceptions of stigma by one’s social network for seeking help for a sexual problem were measured using an adaptation of the 5-item Perceptions of Stigmatization by Others for Seeking Help Scale (PSOSH; Vogel et al., 2009). The three items most highly associated with the overall PSOSH were included in the modified scale without change (worries that seeking help would cause others to “react negatively to you,” “think bad things of you,” and “think of you in a less favorable way”), but the PSOSH instructions were modified to reflect help-seeking for sexual problems rather than for general psychological concerns. Responses were measured on a 5-point Likert scale (1 = not at all, 5 = a great deal), with higher scores indicating greater stigma by social network, or social stigma. We obtained high internal consistency ($\alpha = 0.90$) with the modified version of the scale, comparable to the internal consistency of the original PSOSH ($\alpha = 0.91$; Vogel et al., 2009).

Help-seeking preferences

The fourth measure, unique to this study, was developed to assess the type of professionals from whom participants would most likely seek treatment. Respondents were asked to rate the likelihood that they would seek help for sexual problems from each of five different types of professionals: family physicians/general practitioners, gynecologists/urologists, sex therapists, psychologists, and counselors. A sixth category, midwives, was added to the Swedish surveys because Swedish women frequently seek help from midwives in matters related to contraceptives and sexual health (Nordfjell, 2011). Responses were measured on a 5-point Likert scale (1 = not at all likely, 5 = very likely).
Proceedings

Prior to data collection, the researchers obtained approval from the Institutional Review Boards of both the US and Swedish universities. At the US university, the first author described the study, requested participation, and distributed surveys to college students enrolled in different sections of an introductory health and wellness promotion class. Recruitment was conducted in this course because it is required of all students at the university, regardless of major. (Although class content may involve sexuality education, the primary topics of focus in the class are physical fitness, stress management, interpersonal communication, and health.) The survey began with an explanation of the voluntary and anonymous nature of the research, and students were informed that if they listed their names, their responses would be discarded. Across all classes in which respondents were recruited, only one student returned a survey that was not fully completed.

At the Swedish university, surveys were initially piloted with five students enrolled in an English language class in the effort to ensure that the questionnaire could be fully understood. Because students reported that they did not have any difficulty in comprehending the items, we opted to administer the survey in English rather than translating it into Swedish. However, two small changes were made to the survey as a result of the pilot student feedback: the term “ethnic background” was substituted for “race” in the demographic section of the survey, and the Swedish term for each helping professional was added in parentheses after the English term on the help-seeking preferences scale. The final version of the survey was distributed by professors in the English department during class time. As with the US sample, a brief description of the research as well as information about informed consent was provided in the survey instructions.

Data analyses

All analyses were conducted using SPSS for Windows (version 15.0). Following comparisons of the demographic variables between the US and Swedish samples using $\chi^2$ and $t$-test analyses, we calculated zero-order correlation coefficients among the three attitudinal measures (openness to seeking help, self-stigma, and social stigma). To examine the relationship between these measures and the sociodemographic variables of gender and nationality, we conducted univariate analyses of variance (ANOVAs), with gender and nationality as independent (fixed) variables. ANOVAs were also used to examine the relationship between helping profession preferences and the sociodemographic variables. The level of significance for all analyses was set at $p = .05$.

Results

Openness to seeking help and stigma

Participants in both countries expressed moderate-to-high openness to seeking professional help for sexual problems ($M = 11.90$ (US) and 11.93 (Sweden); theoretical range $= 4–16$). Respondents demonstrated moderate levels of self-stigma associated with seeking help for a sexual problem ($M = 12.67$ (US) and 11.50 (Sweden); theoretical range $= 5–25$) and relatively low levels of social stigma for seeking professional help for a sexual problem ($M = 5.57$ (US) and 5.15 (Sweden); theoretical range $= 3–15$).

Correlations among the three modified scales were performed. Openness to seeking help was negatively and significantly correlated with self-stigma, $r = -0.32$, $p < .001$, indicating that a tendency to self-stigmatize is associated with lessened likelihood of seeking professional treatment. Openness to seeking help was also negatively correlated
with social stigma, though the relationship showed only a trend toward statistical significance, \( r = -0.15, p = .06. \) Self-stigma and social stigma were positively correlated, \( r = 0.44, p < .001. \)

**Sociodemographic variable comparisons**

To examine the relationship between the three attitudinal measures (openness to seeking help, self-stigma, and social stigma) and the sociodemographic variables (gender and nationality), ANOVAs were conducted. For gender, openness to seeking treatment and social stigma showed no significant main effects, but on the self-stigma scale, there was a significant main effect, \( F(1, 154) = 5.70, p < .05, \) with males reporting higher self-stigma than females. For nationality, none of the attitudinal measures showed a main effect, indicating that US and Swedish students did not vary in terms of their openness to seeking treatment, self-stigma, or social stigma. Means and standard deviations for the three measures, by country and gender, are presented in Table 2.

To test the relationship between the three attitudinal measures and religion, two categories of religion were constructed: Christian (Protestant and Roman Catholic) and non-religious (atheist, agnostic, and no religion). Other responses to the item regarding religion (Jewish, Muslim, other, undecided, and no response) were dropped from this set of analyses due to low frequencies of each, resulting in the elimination of a total of 20 participants. Across both countries, ANOVAs revealed significant differences between Christian and non-religious participants with regard to perceptions of self-stigma, \( F(1, 136) = 3.90, p = .05, \) and social stigma, \( F(1, 133) = 10.94, p < .001. \) On both measures, Christians reported higher perceptions of stigma than non-religious participants (self-stigma, \( M = 13.14 \) vs. 11.56; social stigma, \( M = 6.33 \) vs. 4.79). Openness to seeking treatment did not differ between Christian and non-religious participants.

**Help-seeking preferences**

Participants’ ratings regarding the likelihood that they would seek help for a sexual problem from each of five (US) or six (Sweden) different helping professionals were examined. Means and standard deviations for each professional, by country and gender, are presented in Table 3. As is evident from the table, participants from both countries

<table>
<thead>
<tr>
<th>Country and gender</th>
<th>Openness to seeking help</th>
<th>Self-stigma</th>
<th>Social stigma</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
</tr>
<tr>
<td>US</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>11.63</td>
<td>2.18</td>
<td>13.39</td>
</tr>
<tr>
<td>Female</td>
<td>12.14</td>
<td>2.32</td>
<td>12.05</td>
</tr>
<tr>
<td>Sweden</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>12.07</td>
<td>2.23</td>
<td>12.69</td>
</tr>
<tr>
<td>Female</td>
<td>11.83</td>
<td>2.95</td>
<td>10.58</td>
</tr>
<tr>
<td>Overall</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>11.84</td>
<td>2.20</td>
<td>13.04</td>
</tr>
<tr>
<td>Female</td>
<td>11.98</td>
<td>2.66</td>
<td>11.29</td>
</tr>
</tbody>
</table>
Table 3. Helping profession preferences: means and standard deviations by country and gender.

<table>
<thead>
<tr>
<th>Country and gender</th>
<th>Psychologist</th>
<th>Family physician/general practitioner</th>
<th>Gynecologist/urologist</th>
<th>Sex therapist</th>
<th>Counselor</th>
<th>Midwife</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>( M )</td>
<td>SD</td>
<td>( M )</td>
<td>SD</td>
<td>( M )</td>
<td>SD</td>
</tr>
<tr>
<td>US</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>2.39</td>
<td>1.17</td>
<td>3.18</td>
<td>1.38</td>
<td>3.12</td>
<td>1.39</td>
</tr>
<tr>
<td>Female</td>
<td>2.51</td>
<td>1.57</td>
<td>3.42</td>
<td>1.43</td>
<td>3.88</td>
<td>1.38</td>
</tr>
<tr>
<td>Sweden</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>2.40</td>
<td>1.59</td>
<td>3.37</td>
<td>1.55</td>
<td>3.14</td>
<td>1.38</td>
</tr>
<tr>
<td>Female</td>
<td>2.56</td>
<td>1.55</td>
<td>2.56</td>
<td>1.41</td>
<td>4.40</td>
<td>1.01</td>
</tr>
<tr>
<td>Overall</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>2.40</td>
<td>1.40</td>
<td>3.28</td>
<td>1.46</td>
<td>3.13</td>
<td>1.37</td>
</tr>
<tr>
<td>Female</td>
<td>2.54</td>
<td>1.52</td>
<td>2.97</td>
<td>1.47</td>
<td>4.15</td>
<td>1.22</td>
</tr>
</tbody>
</table>
reported relatively more likelihood of seeking help from professionals with medical degrees.

In order to investigate helping professional preferences by country and gender, ANOVAs were conducted for each helping profession, with gender and country as independent variables. (Midwives were not included in these analyses because this option was only present on the Swedish version of the survey.) Significant differences emerged on two categories of helping professionals: family physicians/general practitioners and gynecologists/urologists. The likelihood that participants would seek help from a family physician/general practitioner showed no significant main effects for country or gender, but the interaction was significant, \( F(1, 150) = 5.01, p < .05 \), due to the greater likelihood of Swedish males than Swedish females to report a desire to seek help from family physicians (\( M = 3.37 \) vs. 2.56). In addition, across countries, there was a significant effect for gender in the likelihood of seeking help from a gynecologist or urologist, \( F(1, 150) = 23.35, p < .001 \), with females reporting higher likelihood than males (\( M = 4.15 \) vs. 3.13).

Discussion

This study examined attitudes toward seeking professional help for sexual problems in the US and Sweden. Our results demonstrated that college students from both countries were relatively open to the idea of seeking help for sexual problems and perceived minimal stigma from their social networks about doing so. However, participants in this study reported moderate levels of self-stigma, suggesting that they would likely react to sexual problems with somewhat negative self-judgments but would not expect such judgments from friends or family.

The inverse relationship between openness to seeking treatment and self-stigma, found in the present study, is consistent with prior work with the original ATSPPH-SF and SSOSH scales focused on general psychological concerns (Elhai et al., 2008; Vogel et al., 2006). Not surprisingly, individuals who view help-seeking for a sexual problem as an indication of personal inadequacy or a threat to self-esteem are less open to seeking professional treatment, perhaps one reason why the majority of people with sexual dysfunctions do not seek treatment (e.g., Moreira et al., 2005). As is the case with help-seeking for mental health problems, researchers and clinicians should consider self-stigma as a barrier to seeking treatment for sexual problems. The perception of stigma from one’s social network was also somewhat associated with less openness to seeking help. However, given low levels of social stigma overall in this group of participants, this relationship appeared less substantial.

We also examined the relationship between help-seeking openness and three sociodemographic variables. In regard to gender, although males in both Sweden and the US expressed greater self-stigma toward seeking help for a sexual problem than females, no gender difference in openness to seeking treatment was revealed. This finding is in contrast with the results of previous research indicating that with regard to mental health concerns, females are more open to seeking help than men (e.g., Nam et al., 2010). However, Nam et al.’s (2010) meta-analysis considered only studies describing psychological help-seeking broadly, rather than examining treatment motivation within different symptom categories. Perhaps, openness to help-seeking is not a general disposition, but rather depends on the nature of the disorder. Men may be more amenable to pursuing treatment for sexual dysfunctions because, relative to women, they may view such problems as more significant and disturbing, increasing their motivation for treatment. For example, premature ejaculation, the most frequent sexual dysfunction among young men,
is known to be highly distressing and associated with significant psychological consequences (Rowland, 2011). In addition, women tend to experience more anxiety, guilt, and shame in the sexual arena than men (Petersen & Hyde, 2010), feelings that may inhibit the desire for treatment, where direct conversation about sexual behavior and experiences would be essential.

Related to religious affiliation, participants who identified as Christian across both countries expressed greater self-stigma and social stigma than non-religious participants, results that are consistent with previous research regarding stigma for mental illness (Eisenberg et al., 2009). Yet, despite greater stigma, Christian participants in the present study were no less open to seeking treatment for sexual problems than non-religious participants. Previous research has indicated that religious college students prefer to seek help for psychological problems from a religious advisor (Crosby & Bossley, 2012). Because our measure of openness to treatment did not distinguish between religious and secular treatment, we do not know which type of professional the Christian respondents in our study were envisioning, nor which they would prefer. Nonetheless, we can conclude that in the context of sexual problems, Christianity per se is not a deterrent to help-seeking.

In contrast to expectation, we found no overall differences between US and Swedish participants in openness to seeking help, self-stigma, or social stigma. In spite of sample selection discrepancies (e.g., Swedish students were on average three years older, and were English majors at their university rather than from varied disciplines) as well as potential cultural differences, attitudes were remarkably similar across both countries in our college student samples. While we had anticipated greater comfort on the part of Swedish than US students with respect to sexual dysfunctions and their treatment, our expectation was based in part on a comparison of US–Swedish sexual attitudes that is now more than a decade old (Weinberg, Lottes, & Shaver, 2000). Wells and Twenge (2005) found evidence of increasing permissiveness in sexual attitudes among North American young adults, a trend that has likely continued in recent years, potentially resulting in greater similarity today between US and Swedish college students. Such change may be fueled by increased exposure to sexual issues in the media (e.g., Hara, Gibbons, Gerrard, Li, & Sargent, 2012), and more recently, by the proliferation of direct-to-consumer advertisements for sexual dysfunction pharmaceuticals (see Ventola, 2011, for an extended discussion of potential impacts of direct-to-consumer ads). Interestingly, such advertisements are not currently allowed in the European Union (Arnold & Oakley, 2013).

At the same time, it is possible that the lack of observed difference between the US and Swedish samples is the result of a non-representative US comparison group. More than half of both Swedish and US participants in our study reported that they were non-religious, results that are more similar to Swedish than US national trends. In the US, 80% of college students report that they believe in God (Mooney, 2010), while in Sweden, only 23% of the population report that they believe in God (European Commission, 2005).

Our final topic of inquiry concerned the type of helping professionals from whom participants would seek help if they were to experience a sexual problem. Consistent with previous findings (Shifren et al., 2009), participants from both Sweden and the United States expressed more interest in seeking help from medical professionals (gynecologists/urologists and family physicians/general practitioners) than from sex therapists, psychologists, or counselors. For individuals with psychological concerns, physicians, especially general practitioners, have been found to be the most common point of entry to treatment
In a study of individuals who sought help for sexual problems in a primary care setting, sexual problems were viewed as more legitimate if seen as medical problems (Fitter et al., 2009). Perhaps pursuing treatment in a medical setting carries less stigma than seeking treatment from a mental health practitioner. Interestingly, a commonly cited explanation for why individuals do not seek help for a sexual problem is that they do not consider it to be a medical problem (Moreira et al., 2005).

The finding that participants were more willing to seek help for sexual problems from medical than mental health professionals could be viewed as a health care challenge. For example, general practitioners, the top professional choice for males and second most popular choice for females, are unlikely to be equipped to discuss sexual problems with their patients. Moreira et al. (2005) found that across all nations studied (including Sweden and the US), discussions about sexual health had been initiated by general practitioners in only 9% of participants’ medical visits during the previous three years. The findings of two British studies also suggest that general practitioners rarely discuss the topic of sexual health with their patients due to such obstacles as lack of training, limited time, the sensitive nature of the topic, and personal embarrassment (Gott et al., 2004; Haboubi & Lincoln, 2003). Yet, our results indicate that patients are predisposed to turn to their family physicians for help, a choice that may be reinforced, at least in the US, by the tendency of health care insurers to provide fuller coverage for visits to general practitioners than to either medical or mental health specialists.

A limitation of the present study is our reliance on a college student sample, where stigma may be lower than among individuals who have not attended college. Although research on non-student populations is lacking, more highly educated participants in a large study conducted in Canada reported less stigmatizing attitudes regarding depression than less educated individuals (Cook & Wang, 2010). Vogel et al. (2009) suggested that college students may be predisposed toward lessened stigma because of more positive views of counseling than individuals without university education. The other sample limitation of this research, as previously noted, is that non-religious students appear to be overrepresented in the US student group, and low religiosity is associated with more permissive sexual attitudes among college students (e.g., Brelsford, Luquis, & Murray-Swank, 2011). However, the finding of even a moderate degree of stigma in our younger, educated, and potentially more permissive sample suggests that such attitudes may be even more pronounced in the general population, quite likely affecting help-seeking behavior.

Another drawback of this research concerns the modification of the previously validated scales assessing stigma and openness to seeking treatment. Although the internal consistency of both modified stigma scales was high, the internal consistency of the modified ATSPPH-SF was only moderate, limiting statistical power of the subsequent analyses.

Our findings have implications both for the treatment of and education about sexual dysfunctions. For example, this research highlights the importance of making treatment for sexual problems more widely accessible. As prior researchers have concluded, training primary care professionals in the area of sexual health is crucial (Gott et al., 2004; Haboubi & Lincoln, 2003). Such training would ideally be part of a standard medical school curriculum and could incorporate not only a focus on communication skills in the area of sexual health, but also the concept of self-stigma and its impact on deterring individuals with sexual dysfunctions from seeking treatment. While time limitations will likely continue to be an obstacle to initiating any sort of treatment, if family physicians could comfortably introduce conversations about sexual matters, appropriate assessment
and diagnosis could then take place. The development of strong consulting and referral relationships to professionals specializing in sex therapy is essential so that general practitioners could then seamlessly refer patients whose sexual problems they do not feel equipped to address.

A related point is that knowledge about where to seek professional treatment of sexual dysfunctions appears limited in the general population. For example, it is surprising that across participants from both countries, the likelihood of seeking help for a sexual dysfunction from a sex therapist did not reach even the “somewhat likely” rating level. Arguably sex therapists are the professionals most directly trained to treat sexual dysfunctions, with schedules typically set up to accommodate full-length treatment sessions; future research might address the reasons for this apparent selection bias. More broadly, there may be genuine confusion about appropriate sources for the treatment of sexual dysfunctions, given that many respondents indicated some degree of likelihood of pursuing treatment from each of the listed professionals. Such uncertainty could serve as a barrier to help-seeking among people with sexual dysfunctions (Fitter et al., 2009). At the very least, including information about sexual problems and their treatments in health and sexuality education classes, such as those required in some US and all Swedish public schools, would be beneficial.

Future research should address efforts to lessen the stigma surrounding help-seeking for sexual problems. Sharp, Hargrove, Johnson, and Deal (2006) found that college students who participated in just a 40-minute psychoeducational intervention about mental illness and help-seeking were less stigmatizing and more open to seeking psychological treatment afterward, relative to control group participants. Education about sexual problems and their treatment may likewise positively affect attitudes toward sexual dysfunctions by “normalizing” their existence.

Notes on contributors

Linnea Bergvall, BA, is an alumna of the psychology department at the University of North Carolina Asheville. She is currently applying to graduate programs and hopes to pursue a career in counseling with emphasis in sex therapy.

Melissa Himelein, PhD, is a professor of psychology and the director of the Center for Teaching and Learning at the University of North Carolina at Asheville. Her teaching and research interests include clinical health psychology and the psychology of women.

References


