COUNSELORS' EXPERIENCES WITH SUCCESSFULLY INTEGRATING SEXUAL HEALTH INTO CLINICAL PRACTICE: A QUALITATIVE PHENOMENOLOGICAL STUDY

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by

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DEDICATION

To my professional mentors, educators, family, and friends. Thank you for the endless amount of patience and love you shared with me as I completed my graduate education. You've been with me every step of the way on this journey, challenging me and cheering me on. Thank you for encouraging my creativity and providing safe spaces for me to grow and flourish. Because of you, I am joyfully and proudly here.

ABSTRACT

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Counselors have neglected the topic of sexual health in their discussions and work with clients. Despite on-going research and expansion on sexual health topics, counselors continue to report discomfort, lack of knowledge, and low self-efficacy as reasons for why they are reluctant to discuss sexual health. When counselors fail to inquire about or address sexual health topics with clients, comprehensive care could be compromised, and clients might not be receiving the treatment necessary to produce desired outcomes to enhance overall wellbeing. To address this concern, counselors and educators might consider adopting and applying the attitudes and behaviors of counselors who have successfully integrated sexual health into their counseling work with clients.

This study expanded upon the work of Sangra (2016) by exploring the experiences of Licensed Professional Counselors (or equivalent) who reported having successful integration of sexual health into their clinical practice as a means to understanding the elements contributing to increased level of comfort, self-efficacy, and ultimately comprehensive care. A qualitative, semi-structured interview was completed with 11 participants. Successful integration of sexual health into clinical practice was demonstrated by four themes: perception of counselor's role, counselor sexual health self-efficacy, sex-positive attitude, and sexual identity development. Results, discussion, and future recommendations to improve counselor education and training for sexual health topics are included in the study.

KEY WORDS: Sexual health; Human sexuality; Counselor education

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CHAPTER I

Introduction

The role of a counselor includes providing competent and ethical care while ensuring our client's needs are explored and addressed comprehensively (American Counseling Association [ACA], 2014). Counselors have an ethical responsibility to provide treatment, which in turn will alleviate client distress and improve overall wellbeing. Across time, researchers and clinicians have become more aware of various client issues, including *sexual health*, as social and public health interests that encompass physical, social, mental, and emotional wellbeing related to sexuality, and an overall positive approach to sexuality and sexual relationships (World Health Organization [WHO] 2010, Center for Disease Control and Prevention [CDC], 2019). Moreover, client needs regarding sexual health are likely to come up when working both with individuals and couples (Hipp & Carlson, 2019). Additionally, counselors have a responsibility to ensure that sexual health is actively integrated into clinical practice to promote overall wellbeing (Buehler, 2017, Sangra, 2016).

Sexual health is an important aspect of counseling work and must be explored, understood, and addressed in ways that are clinically appropriate and comfortable for the client (Russell, 2012). Ethically speaking, when clinicians hold out on having important sexual health related discussions, they not only deprive the client from comprehensive care, but also perpetuate the lack of discussion about sexual health that prevents clients from talking about it to begin with (Buehler, 2017; Russell, 2012). Despite extensive research completed on sexual health topics over the last century, clinicians continue to neglect integrating sexual health into their practice, potentially impeding the fullness of

client recovery and wellbeing (Buehler, 2017). Existing research on this topic has historically focused on the shortcomings of counselors and how they integrate sexual health issues into practice rather than focusing attention on successful practitioners who already deliver quality care. Thus, a significant gap remains on how to best address sexual health issues within the therapeutic work.

Having a better understanding of successful sexual health integration in counseling practice could serve to inform counselor training and supervision, thereby better preparing future counselors to address sexual health issues into practice and better meet client needs. Understanding sexual health and integrate sexual health discussions in counseling could potentially be achieved through understanding the experiences of counselors who have moved passed the barriers presented in the above research. Therefore, the present study explores the experiences of mental health professionals who have successfully integrated sexual health into their clinical practice to address the sexual health and sexual wellbeing of their clients.

Background of the Study

Sexual health research and clinical work began with Alfred Kinsey, a pioneer in the study of sexuality and who published The Kinsey Reports, a compilation of data, analyses, and conclusions regarding human sexuality and sexual behaviors of men and women (1948, 1953). Additionally, William H. Masters and Virginia E. Johnson detailed stages of sexual response and treatment of sexual dysfunction respectively (1966, 1970). More recently, following the sexual revolution in the 1960s, researchers have discussed the clinical implications related to sexual health (Buehler, 2017; Harris & Hays, 2008; Miller & Byers, 2008; 2010; Russell, 2012). It is clear that researchers have

acknowledged the importance of integrating sexual health into clinical practice to provide ethical and comprehensive care (Buehler, 2017; Russell; 2012).

Sexual health research has typically focused on the limitations of counselors and healthcare professionals alike when addressing sexual health topics in practice (Buehler, 2017; Russell, 2012, Southern & Cade, 2011). Several counselor characteristics discussed in the literature listed as barriers to successful integration include: negative attitudes about sex (Anderson, 2002; Buehler, 2017; Dermer & Bachenberg, 2015; Dupsoki, 2012; Harris & Hays, 2008; Russell, 2012), lack of knowledge (Dermer & Bachenberg, 2015; Graham & Smith, 1984; Haag, 2008; Lewis & Bor, 1994; Weerakoon, Sitharthan, & Skowronsk, 2008), and low sexual health self-efficacy (Dermer & Bachenberg, 2015; Miller & Byers, 2008; Russell, 2012). To date, only Sangra (2016) has approached this topic from a different stance and by exploring the successful integration of sexual health into counseling work as opposed to the barriers of addressing sexual health.

Integrating Sexual Health into Counseling

Sexual health is an aspect of being that touches all individuals in various capacities. At the most basic level, the simple existence of humans is rooted in sexual experience. However, researchers have consistently highlighted the shortcomings of mental health professionals in addressing sexual health topics, leaving the process and experience of successful integration a mystery (Russell, 2012). Despite the broad influence of sexual health, the integration and importance placed on sexual health by practicing mental health professionals remains unclear (Russell, 2012).

Better understood is that distress related to sexual health topics among the clinical population is prevalent (Buehler, 2017). According to the Cleveland Clinic (2016), at

least 43 percent of women and 31 percent of men reported some degree of difficulty with sexual health and functioning. Similarly, Shaeer and Shaeer (2012), who administered the Global Online Sexuality Survey, found that up to 38 percent of men reported some form of sexual difficulty. The Diagnostic and Statistical Manual of Mental Disorders (DSM 5; American Psychiatric Association, 2013) includes over a dozen sexual health related disorders and dysfunctions. The prevalence of sexual health issues is well understood, meaning that counselors working with individuals and couples are very likely to come across clients with sexual health concerns (Hipp & Carlson, 2019).

Nevertheless, healthcare professionals and mental health professionals remain reluctant to integrate sexual health into their practice despite the need to address sexual health issues and incorporate discussions about sexual health (Buehler, 2017; Dermer & Bachenberg, 2015; Dupsoki, 2012; Harris & Hays, 2008; Russell, 2012; Wilson, 2017). Ninety-four percent of healthcare workers reported that they would not initiate conversations about sex with their patients (Haboubi & Lincoln, 2003). Across the mental health profession, only twenty-one percent of clinicians reported asking their clients about sexuality-related issues (Miller & Byers, 2010). And according to Buehler, about half of all mental health professionals are neglecting conversations about sex with their clients (2017). Conversations about sex that are avoided by clinicians could also reinforce negative scripts and messages about sexual health (Buehler, 2017), potentially widening the space between the client, counselor, and presenting issues, and moving away from building a strong, accepting therapeutic alliance (Russell, 2012).

At the time of this study, counselor education, training, and supervision fell short in providing sufficient resources for clinicians to be prepared to discuss sexual health

with clients (Buehler, 2017; Russell, 2012). Programs preparing students to become Licensed Professional Counselors (LPC) under the Council for Accreditation of Counseling and Related Educational Programs standards required no training in human sexuality (CACREP, 2016), something supported by clinicians across various research studies in which students and counselors report they are ill-prepared due to lack of knowledge and training (Buehler, 2017; Russell, 2012; Haag, 2008; Weerakoon, Sitharthan, & Skowronsk, 2008; Graham & Smith, 1984). This lack of education includes being unaware of the many facets that encompass overall sexual health, including sexual functioning, presence or absence of infection or disease, sexual choice and preferences, and sociocultural factors on sexual self (Russell, 2012).

Due to inadequate training on sexual health topics, clinicians have expressed negative attitudes about sexual health topics and discomfort when addressing sexuality with clients (Buehler, 2017; Dermer & Bachenberg, 2015; Dupsoki, 2012; Russell, 2012; Harris & Hays, 2008). In one study, Gregory and Paylo (2020) administered a questionnaire to 939 LPCs to inquire about the importance of, comfort with, and process of assessing a client's sexual history during the intake process. The researchers had results that were similar to previous studies, showing that while counselors believe sexual health integration is important, they experience discomfort or withhold from assessing the client's sexual history altogether (Gregory & Paylo, 2020). Furthermore, clinicians have consistently report low self-efficacy, stating that they believe they do not have the skills or knowledge base to effectively treat sexual health-related issues (Dermer & Bachenberg, 2015; Miller & Byers, 2008; 2010; Harboubi & Lincoln, 2003). This lack of

professional training could potentially students to lean on their own beliefs and values as opposed to best practice methods for addressing sexual health topics (Russell, 2012).

Despite the barriers and impact of barriers discussed above, some counselors are able to bridge the gap between sexual health and clinical practice and are professionally prepared to discuss sexual health topics with their clients (Gregory & Paylo, 2020; Hipp & Carlson, 2019, Sangra, 2016). For example, Sangra (2016) interviewed three counselors who self-reported successfully integrating sexual health into their practice, which included discussing sexual health with clients and initiating sexual health discussions as needed. To date, no other studies have been completed with professional counselors who do not experience barriers to addressing sexual health. Equipping students with knowledge and skills to address sexual health issues leads to shifts in personal attitudes and beliefs, improved conceptualization of sexual health issues, and ultimately improved treatment planning and therapeutic work (Russell, 2012).

Theoretical Framework

Social constructivism will serve as the theoretical framework for this study. Social constructivism asserts that individuals arrive at their own understanding of reality or truth through their interactions with others within a cultural context. This theory is rooted in the research of Vygotsky and Luria (1930) and Vygotsky (1978), who asserted that learning and development is a result of social interactions and an integration of social experiences. By reflecting on our own experiences and knowledge, we construct meaning and understanding of the world we live in. Furthermore, collecting social information gathered from collaborative interactions creates our *script* or *schema* for understanding various aspects of the human experience (Vygotsky, 1978).

The theory of social constructivism closely aligns with the counseling profession. The collaborative nature of counseling mimics the collaborative nature of learning, particularly from a cultural and social context (Cottone, 2001; Vygotsky, 1978). Counselors understand client behavior through the experiences of the client from a social lens (Cottone, 2017). According to Davila (2005), the messages and scripts developed out of interactions with one's environment and influence their behavior.

Given that sexuality has a strong sociocultural and political influence (Giami, 2002), social constructivism provides an appropriate lens through which clinician level of comfort and attitudes can be examined. By understanding and breaking down negative messages and scripts about sexual health that are learned from experiences and interactions with others, counselors can become more comfortable and proactive when addressing sexual health. Additionally, counselors collectively sharing previously constructed positive messages about sexuality may influence the schema of other clinicians who are less comfortable with issues of sexual health in session, leading to schemas promoting increased discussion of sexual health with clients.

Statement of the Problem

Existing literature almost exclusively points to the barriers and limitations of counselors when addressing sexual health topics in practice while neglecting factors which promote successful integration (Buehler, 2017; Russell, 2012, Southern & Cade, 2011). Clinicians may have difficulty addressing sexual health concerns or topics due to a lack of proper training (Russell, 2012). For instance, beyond the Council for Accreditation of Counseling and Related Education Program's (CACREP, 2016) written commitment to comprehensive training across all major facets of human functioning, no

specific training in the realm of sexual health is required. The omission of sexual health education and strategies for clinical integration of sexual health has potential to negatively influence client interpersonal relationships, self-esteem, sexual development, and overall outcomes of treatment (Russell, 2012). A focus on counselor's barriers to addressing sexual health, coupled with high need to integrate sexual health, leaves a major discrepancy in clinical practice (Buehler, 2017; Russell, 2012; Sangra, 2016).

Purpose of the Study

The purpose of this study is to explore the experience and practices to reduce barriers to addressing sexual health and improve quality comprehensive care. To this point, only a few studies have given a voice to counselors who do not experience significant barriers to addressing sexual health issue and even fewer have focused on the Licensed Professional Counselor (LPC; or equivalent) population (Gregory and Paylo, 2020; Sangra, 2016). Given the prevalence of sex-related concerns among the clinical population (Buehler, 2017; Sangra, 2016) and the counselors ethical duty to provide comprehensive care (American Counseling Association [ACA], 2014; Russell, 2012), clinicians should be prepared to integrate sexual health into their practice and be comfortable doing so to ensure the needs of clients are met comprehensively and ethically.

Significance of the Study

With the information gathered and presented in this study, counselor educators and supervisors can modify their curricula and approaches to mirror the practices of counselors who have previously and successfully integrated sexual health into their work. Counselors and counselor education programs can improve their practice and training by

understanding and adopting the experiences of clinicians who are already successfully integrated sexual health into their clinical practice.

Definition of Terms

The following definitions are provided to ensure an accurate understanding of the terms in the context of the study:

Clinician

According to Buehler (2017), there are several terms used to describe individuals working in the helping profession such as therapists, professional counselors, psychiatrists, psychologists, psychiatric nurses, social workers, and marriage and family therapists. For the purpose of this study, the term *clinician* refers to mental health professionals, specifically, professional counselors and general therapists.

Licensed Professional Counselor (LPC)

According to the Texas Administrative Code, a Licensed Professional Counselor is, "a person holding an LPC license as a professional counselor with authority to practice in independent practice" (2020). This includes professional counselors who have completed their supervised internship requirements, indicating full licensure status. For the purpose of this study, Licensed Professional Counselors or LPCs as defined by the Texas Administrative Code were interviewed, in addition to professional counselors who have meet their respective states requirements for independent practice (i.e. "or equivalent").

Nonspecialized

This term refers to mental health professionals, including licensed professionals, who have a self-identified specialty not including a sex-related area or no specialty area identified, sex or otherwise-related. For the purpose of this study, *nonspecialized* refers to participants who have not completed any certification in sexual health, although they might have sought additional knowledge or training in sexual health to complement or enhance his or her practice.

Sex Positive

This term refers to "having or promoting an open, tolerant, or progressive attitude towards sex and sexuality" ("Sex-positive," 2021).

Sexual Health

This term is defined by the Center for Disease Control and Prevention (CDC; 2019) and the World Health Organization (WHO; 2002) as,

> a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence

This definition embodies the broad nature of sexual health and sexual health topics.

Research Questions

This study addresses the following qualitative research question: *What are the experiences of counselors who have successfully integrated sexual health into their work with clients?* The research question was designed to facilitate a phenomenological

qualitative inquiry to explore unique individual experiences with the phenomenon and the common meaning that has been created through the experience (Creswell & Poth, 2018).

Limitations

This study specifically explored the experiences of Licensed Professional Counselors (or equivalent) with successful integration of sexual health into clinical practice through the phenomenological lens. Therefore, the data does not reflect the experiences of other licensed professionals or healthcare providers who may have also successfully integrated sexual health into their practice. Participants in this study self-reported their successful integration of sexual health. This understanding and perception of successful integration may vary across clinician and therefore may be inconsistently represented in the data. Additionally, although the study was open to participants at the national level, most participants engaging in the study were limited to certain geographic areas, which does not necessarily reflect the overall experiences of licensed clinicians across the nation or who have been trained through various programs or abide by varying state codes among statues with varying licensure requirements.

Delimitations

This study was delimited to Licensed Professional Counselors or equivalent who had obtained full status licensures in their respective states and had been actively practicing for a minimum of one year under their full licensure status. Clinicians who held alternative licensures, dual licensures, or sex-related certifications were not included in this study. This study was also delimited to LPCs who self-reported successful integration of sexual health discussions with their clients.

Assumptions

Several assumptions were made to solidify the foundation for this study. First, I assumed that all participants provided an honest and accurate account of their experiences with the phenomena. Second, I assumed that all participants successfully integrated sex and sex-related issues into their clinical practice with their clients. Third, I made a broad assumption that all participants had a generally collective view of what is considered "successful" integration. Finally, I assumed that the chosen methodology, transcendental phenomenology, was the most appropriate method for obtaining data relevant to clinician's true and rich experiences.

Organization of the Study

This dissertation consists of five chapters and is organized in the following manner: Chapter I is the introduction to the study, statement of the problem, purpose statement, significance of the study, definition of terms, research questions, limitations, delimitations and assumptions. Chapter II is a thorough review of the literature on sexual health, including sexual health history, counselor education, training, supervision, and integration of sexual health into clinical practice. Chapter III is a description of the transcendental phenomenology and includes the processes I used to gather and analyze the data. Chapter III also includes information about participants, data collection, and data analysis of the study. Chapter IV includes a description of the demographic data and a comprehensive presentation of qualitative analyses. Chapter V contains a summary of the research, a discussion of the results, and implications for the field of counseling and counselor education. Chapter V also includes limitations of the research and recommendations for future research.

CHAPTER II

Review of the Literature

Sexual health concerns encompass a diverse range of sex-related topics centered around safety, health, and well-being of individuals, partners, and communities (World Health Organization [WHO], 2010; Center for Disease Control and Prevention [CDC], 2019). And because a major goal of the counseling profession is to promote overall health and well-being of clients and communities, including identifying and addressing sexual health needs counseling needs of clients, when appropriate, supports them in reaching their therapeutic goals. Unfortunately, the clinical response to addressing sexual concerns of clients is underwhelming (Buehler, 2017).

Clinician's attitudes and beliefs abouts sex, lack of knowledge and skills, and discomfort toward sex-related discussions are potential barriers to providing comprehensive care, which could negatively impact overall client well-being (Buehler, 2017). Given that counselor education and training is pivotal in preparing clinicians to address a variety of issues, the lack of focus on human sexuality during counselor training programs risks perpetuating negligence when addressing sexual health topics with clients (Buehler, 2017). In contrast, understanding the experiences and practices of clinicians who have successfully integrated an understanding and awareness of sexual health into their practice could inform counselor training, education, and preparatory programs, thereby encompassing a more complete comprehensive care approach, reducing the stigma of sexual health and sexual concerns, enhancing client-counseling relationships, and potentially improving client outcomes.

This literature review was developed to (a) provide a comprehensive understanding of what sexual health entails, (b) review counselor education, training, and preparation factors that inform clinical practice, (c) describe barriers to successful integration of sexual health into clinical practice, and (d) identify gaps in the literature describing successful integration of sexual health in counseling work.

Sexual Health

Sexual health has a long-standing history involving social, political, physical, and religious friction (Giami, 2002). The history and progression with regard to addressing sexual health concerns was accompanied by the development and clarification of its definition and corresponding contributions to the field. According to the World Health Organization (WHO; 2010) and the Center for Disease Control (CDC; 2019), sexual health has come to be an umbrella term encompassing the emotional, mental, physical, and social facets of well-being in regard to sexuality. Additionally, sexual health includes approaching sexuality from the lens of safety and health in relationships and all sexual experiences (WHO, 2010; CDC, 2019). Given that health and wellbeing overlap with the counseling profession, sexual health topics are fair game for therapeutic work with clients (Russell, 2012). These topics include, but are not limited to, sexual anatomy, sexual development, women's and men's issues, medical concerns, medication usage, relationship implications, sex-related trauma, and co-occurring mental health concerns (Buehler, 2017).

With the support of ample data rich in variety, researchers have determined that sexual health is currently not effectively integrated in the clinical work that counselors are doing with their clients (Buehler, 2017; Russell, 2012). In other words, the presence

of sexual health concerns is highly discrepant from the evidence of clinical response (Buehler, 2017), suggesting that sexual health concerns are not discussed in counseling or are minimally discussed. Worth noting, these discussions that are *not* taking place regarding sexual health in a seemingly safe space could perpetuate client shame about sex as well as dated societal expectations that sex should not be discussed (Buehler, 2017).

According to Russell (2012), limited or complete lack of training in regards to sexual health is a barrier to providing comprehensive care and can be detrimental to overall client wellbeing. In regards to sexual health, clients have reported a variety of reasons that sexual issues were not addressed in their clinical work, ranging from therapist refusal to treat sex-related concerns, client's perception that their therapist was uncomfortable talking about sex, or a lack of opportunity or openness in session to discuss sexual issues (Buehler, 2017).

At the time of this study, there was no human sexuality requirement to become a Licensed Professional Counselor (or equivalent) under the Counsel for Accreditation of Counseling and Related Educational Programs guidelines (CACREP, 2016). Additionally, Licensed Marriage and Family Therapists are only required to complete one three-hour course on human sexuality across the duration of their entire program under the same accrediting body. The disconnect between sexual health concerns or discussions and counselor response (or lack thereof) could be linked to lack of counselor preparation and training for sex-related topics and issues (Russell, 2012). Based on the lack of human sexuality education alone, it appears that human sexuality is often overlooked or disregarded in training programs (Buehler, 2017). This lack of integrated training in many counseling programs means that for most clinicians, learning effective ways to

address sexual topics requires seeking specific trainings and incurring additional expense, time, and travel (Buehler, 2017).

History of Sexual Health

The topic of sexual health as a science made its debut in the early 1900s in Germany with the publishing of *The Homosexuality of Men and Women* (Hirschfeld, 1914). This book provided a description of homosexuality to address heterosexual prejudice and judgement while promoting self-acceptance of gay and lesbian men and women (Hirschfeld, 1914). Around the same time, Iwan Bloch (or Ivan Bloch), also in Germany, began to consider the social and cultural implications and influences on sex, shifting a traditionally pathological view of sexual health to a physiological, biological, and anthropological view (Coles, 2017). While Hirschfeld and Bloch furthered discussions about sexuality in Germany, in 1938 Alfred Kinsey, a pioneer in the field of sexology, began studying sex and orgasm-seeking behaviors (Coles, 2017). He founded the Institute of Sex Research in 1947 and went on to publish *Sexual Behavior in the Human Male* in 1948 and *Sexual Behavior in the Human Female* in 1953, collectively referenced as The Kinsey Reports (Coles, 2017). The Kinsey Reports included extensive data, analyses, and conclusions regarding human sexuality and sexual behaviors of men and women (Kinsey, Pomeroy & Martin, 1948; Kinsey, Pomeroy, Martin, & Gebhard, 1953).

Other pioneers in the field of sexual health included William H. Masters and Virginia E. Johnson. Two books, *Human Sexual Response* (Masters & Johnson, 1966) and *Human Sexual Inadequacy* (Masters & Johnson, 1970) detailed stages of sexual response and treatment of sexual dysfunction, respectively. Masters and Johnson (1966;

1970) also highlighted social and cognitive considerations in addressing sexual health topics. Their work alongside the introduction of oral contraception and the subsequent sexual revolution in the 1960s. During this time, perspectives regarding sexual health shifted to encompass sexual activity without the intent to procreate, both within and outside of martial partnerships (Giami, 2002). In essence, understanding of sexual health expanded to include sexual activity independent of procreative purpose (Giami, 2002).

With the stark shift in social perspectives regarding sexual health, new concerns emerged, such as the human immunodeficiency virus and acquired immunodeficiency syndrome (HIV/AIDS) epidemic beginning in the 1980s, which widened the scope of sexual health to include communities and populations instead of individual persons (Giami, 2002). While public health efforts were made, such as mass surveys on sexual behavior, to inform treatment, government and agency control of individual's sexual choice and behavior raised concerns about the public's overinvolvement in individuals' sexual experiences (Giami, 2002).

As controversy developed surrounding sexual health topics, powerful trailblazers in the field of sexual health continued to emerge, such as Helen Singer Kaplan (1974; 1975), Sue Johnson, Dr. Ruth Westheimer, and, more recently, Esther Perel. While political involvement and regulation of sexual health topics continued to be an area of major controversy in the United States, sexual health research, training, and public education efforts led by these sexual health experts continued to progress.

Sexual Health Definition

Across the United States, *sexuality* and *sexual health* are often used interchangeably (WHO, 2004). The term *sexual health* encompasses many diverse layers

related to sexuality (Russell, 2012) and was developed at a 1975 conference held by the World Health Organization and used to develop programs to address public health concerns internationally. It is rooted in the concept of *health*, which the World Health Organization defines as, “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1946, p.1). Thus, sexual health is not limited to discussions about treatment and prevention, but includes psychological, social, environmental, and societal elements as well. It creates space for wellbeing in a formally pathologized framework. While the definition of *health* has not been changed by the World Health Organization since its introduction in 1946, the way in which *sexual health* has been discussed and applied across various contexts has changed and differed substantially (Giami, 2002).

Following the induction of the term, sexual health became a governmental and individual responsibility. The governmental responsibility included the development and maintenance of sexual health related services and access to such services, while individual responsibility included engaging in practices that encouraged and supported overall health and well-being.

Training of health professionals in *sexology* (the study of sex and sexuality) was initially proposed in 1972 (WHO, 1972). A subsequent WHO report developed by clinical sexologists (primarily physicians with some psychologists and sociologists) included the definition of sexual health, issues and concerns related to sexuality, possible interventions for sexual issues, and a proposed training program for health professionals with specific role functions identified. The authors of the report also indicated that a

change in attitudes regarding sexual health was necessary among health professionals (Giami, 2002). In 1975, the following definition of sexual health was introduced:

> Sexual health is the integration of the somatic, emotional, intellectual, and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication, and love. Thus the notion of sexual health implies a positive approach to human sexuality, and the purpose of sexual health care should be the enhancement of life and personal relationships and not merely counseling and care related to procreation or sexuality transmitted diseases. (WHO, 1975, p. 41)

This definition of sexual health promotes well-being and maintains a positive view of sexuality (Giami, 2002). In 2002, the WHO in collaboration with the World Association for Sexology (WAS) explored the current state of sexual health and related topics and their role in providing guidance to nations, policy makers, and providers when addressing sexual health. The corresponding report, *Defining Sexual Health* (WHO, 2002), proposed the following definition of sexual health:

> Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. (WHO, 2002, p. 5).

The latest working definition encompasses the many areas of functioning that influence sexual health while also maintaining the positive view of sexuality initially proposed in 1975. Although other definitions have been proposed and developed between 1975 and 2002 (Lottes, 2000; Pan American Health Organization & World Association of Sexology, 2001; U.S. Department of Health and Human Services, 2001; The National Strategy for Sexual Health and HIV, 2001; Robinson et al., 2002), the most recent working definition per the WHO also includes mental health, sexual responsibility, and sexual rights (Edwards & Coleman, 2004).

Given that previous definitions have been influenced by social and political events and contexts, future events will likely influence the continued development of the term (Edwards & Coleman, 2004). And because of the elaboration and advancements made to the definition of sexual health, it remains important to continuously clarify what sexual health means and entails to ensure common understanding when discussing sexual health topics (Edwards & Coleman, 2004).

Sexual Health Topics

According to The Laumann survey of female and male sexual problems, 60% of women and 30% of men report having some sort of sexual dysfunction (Laumann et al., 1999). More recently, 43% and 31% of women and men respectively report experiencing some level of sexual dysfunction (Cleveland Clinic, 2017). Health and medical concerns as they relate to sexuality is another sexual health topic, which includes knowledge about medical conditions, treatment, side effects, and sexually transmitted infections (STIs) to name a few (Buehler, 2017; Zeglin, Niemela, & Vandenberg, 2019). To complicate matters, many medical conditions and/or medications present with comorbid sexual

concerns, which can ultimately impact the individual's experience of sexuality (Zeglin, Niemela, & Vandenberg, 2019).

According to Edwards and Coleman (2004), research on the topic of sexual health most often included sexual functioning, sexually transmitted diseases, and reproductive health. This finding, however, is inconsistent with the broad scope of sexual health topics implied by the WHO in its 2002 working definition of sexual health, which include, but are not limited to sexual anatomy and physiology, psychosexual or sexual development, women and men's sexual health, medical/health concerns, medication usage, minority populations, relationship implications, trauma, assessment and treatment, sexual identity, pleasure and sexual lifestyles, sexual exploitation, and mental health (Buehler, 2017; Zeglin, Van Dam, & Hergenrather, 2018). Based on these findings, research into sexual health remains incomplete when compared to the WHO's working definition of sexual health.

One foundational area for knowledge and competency is sexual anatomy, which is an underrepresented sexual health topic in counseling research (Zeglin, Niemela, & Vandenberg, 2019). Knowledge of sexual anatomy includes an understanding the internal and external structures related to sex and sexuality and an understanding of physiological sexual functioning (Nagoski, 2015; Zeglin, Van Dam, & Hergenrather, 2018). Another area, psychosexual or sexual development includes an understanding of stages and the ability to conceptualize sexual issues across the evolving life of an individual (Buehler, 2017; Kaplan, 1974; Zeglin, Niemela, & Vandenberg, 2019) and is a specialty area that falls under the umbrella of sexual health is women's and men's sexual health. Yet another topic under the sexual health umbrella is interpersonal relationships, which can

influence sexual health. Interpersonal relationships comprise emotional, spiritual, and/or sexual intimacy (Zeglin, Niemela, & Vandenberg, 2019). According to Ainsworth, Blehar, Waters, & Wall (1978), attachment styles are factor that could influence sexual aspects of an interpersonal relationship, with secure attachment styles promoting safer and more comfortable sexual experiences. Alternatively, sexual health (such as sexual history, experiences, beliefs and behaviors) could influence also interpersonal relationships (Buehler, 2017).

Going further, interpersonal functioning and individual wellbeing alike can be influenced by the experience of sexual trauma or exploitation. According to Buehler (2017), one in four women and one in six men are molested as children. Molestation, trauma, and exploitation include power dynamics which are used to control and manipulate others (Zeglin, Niemela, & Vandenberg, 2019). Sexual trauma and exploitation include sexual coercion, sexual abuse, trafficking, and forced prostitution (Buehler, 2017; Constable, 2009; Zeglin, 2014; Zeglin, Niemela, & Vandenberg, 2019). These topics alone exemplify the diversity across sexual health issues, expanding the limited scope of sexual health that is often discussed in the literature.

Finally, sexual health concerns may present when addressing other seemingly unrelated mental health concerns (WHO, 1975, p. 43). Clinicians often fail to recognize that sexual issues contribute to anxiety, depression, eating disorders, substance abuse, trauma, etc. (Buehler, 2017). Conversely, a variety of mental health concerns can also contribute to sexual issues (Buehler, 2017). The interconnected relationship between sexual health and mental health concerns is often neglected in session and this oversight

may prevent a clinician from addressing a potentially distressing concern for the client (Buehler, 2017).

Counselor Education and Training

A clinician's education and training is integral in preparing them to work with clients from diverse backgrounds across a variety of topics. Counselor education and training includes the knowledge and skills they acquire during their graduate schooling, adherence to relative professional standards and codes, supervision and consultation, continuing education, and specialty training (CACREP, 2016). According to the World Health Organization (1975, p. 43), education followed by counseling and therapy is the highest priority to promoting and sustaining effective sexual health care practices. Therefore, effective education and training with clients regarding sexual health topics is necessary to ensure that clinicians are prepared to work with these populations.

Russell (2012) suggests that an increase in sexual health knowledge is associated with a decrease in perceived barriers to addressing sexual issues, which may lead to an overall higher level of comfort with addressing sexual concerns with clients. Additional training, continuing education, agency-based training, and sexual health-based supervision are all methods proposed to prepare clinicians to work effectively with clients experiencing sexual health concerns (Diambra, Pollard, Gamble & Banks, 2016; Jennings, 2014; McGlasson et al., 2014; Russell, 2012). Encouragingly, the inclusion of human sexuality training in counselor education programs has gained traction over the last several decades (Dermer & Bachenberg, 2015; Sanabria & Murray, 2018; Southern & Cade, 2011).

Yet despite recognition of the importance of sexual health knowledge and training, counselor education and preparation are rarely infused with sexuality information, resulting in clinicians that are ill-prepared to address sexual health topics with clients (Sanabria & Murray, 2018). Moreover, the clinical supervision included in graduate level counselor education programs reflects a lack of training for both supervisors and students in sexual health topics and concerns (Farago, 2020), increasing the chances for misinforming, diagnosing, and mistreating clients as a consequence of poor or ineffective knowledge, training, and supervision (Sanabria & Murray, 2018).

American Counseling Association (ACA) Code of Ethics

It is necessary that clinicians know and apply ethical standards and operate within the guidelines of various codes of ethics or educational standards for the respective field within which the clinician works (Dermer & Bachenberg, 2015). Clinicians understand and apply skills and interventions most effectively when they operate within the scope of their respective professional ethics and standards (Zeglin, Van Dam, & Hergenrather, 2018). As stated in the ACA Code of Ethics A.1. a (ACA, 2014, p. 4) counselors have a responsibility to promote the welfare of clients. This indicates that professional counselors must ensure that they are practicing in such a way that benefits the client and respects their dignity. The ACA Code of Ethics also states in C.2.a (ACA, 2014, p. 8) that counselors have a professional responsibility to practice within the boundaries of their competency level, which is determined by their level of education, training, supervision, and professional experience (ACA, 2014). Given that professional counselors have a responsibility to ensure the welfare of their clients while also operating within the scope of their competency level, it is essential that professional counselor are equipped with

necessary training to address sexual health concerns that may arise through the course of their work with clients (ACA, 2014; Beuhler, 2017).

The ACA Code of Ethics further states in A.11.b (ACA, 2014, p. 6) that professional counselors must refrain from referring clients to other clinicians or services solely based on their personal attitudes, beliefs, values and behaviors. Counselors have a responsibility to seek training if they are at risk of imposing their beliefs onto their clients or their values become problematic to the work within the counseling relationship (ACA, 2014). Given that sexual health has been associated with negative attitudes and beliefs, it is imperative that professional counselors assess their own biases and assumptions about sexual health and work to mitigate possible risks in the counseling process and relationship (Buehler, 2017). Inability to address personal biases and assumptions may lead to client abandonment, which is outside the scope of ethical practice for professional counselors (ACA A.12, 2014, p. 6).

Counselor Education Programs

A major goal of counselor education programs is to prepare individuals to provide quality care and meet the mental health needs of those being served. To this end, counselors play an integral role in supporting and guiding the work done with clients. However, only approximately 8% of all 537 CACREP-accredited programs required a sexuality-related course (Dermer & Bachenberg, 2015). The lack of education and training requirements could likely perpetuate the difficulty clinicians experience; graduates from these programs are often not prepared to address client sexual health issues once they transition into the clinical world (Dermer & Bachenberg, 2015; Sanabria & Murray, 2018; Zeglin, Van Dam, & Hergenrather, 2017).

According to Russell (2012), due to lack of professional training, clinicians appear to lean on their own values and beliefs about sexual health to guide treatment instead of best practice methods and appropriate training. Given that attitudes and knowledge are related to addressing sexual health concerns with clients, training and opportunities for skill development are necessary components of counselor education programs. And because human sexuality is an important layer in overall client health and wellness, some researchers have discussed the importance of formally integrating human sexuality training in counselor education programs (Dermer & Bachenberg, 2015; Fyfe, 1980; Sanabria & Murray, 2018; Southern & Cade, 2011; Zeglin, Van Dam, & Hergenrather, 2017), as well as proposing changes to counselor education and training programs to incorporate human sexuality components (Dermer & Bachenberg, 2015; Sanabria & Murray, 2018; Zeglin, Van Dam, & Hergenrather, 2017). Sanabria and Murray (2018) proposed an infusion model of sexuality education suggesting that programs should include human sexuality topics across separate counselor education courses. Furthermore, Sanabria and Murray (2018) asserted that basic knowledge of human sexuality included and addressed throughout the training program would decrease the likelihood of counselors being underinformed or misinformed about sexual health topics. These suggestions followed Sammons and Speight's (2008) research on multicultural training., which indicated that up to 70% of students reported an increase in self-awareness and knowledge after a single multicultural course (However, and importantly, they also reported minimal change in attitudes and behaviors, possibly due to limited exposure to the topic area, suggesting the importance of meaningful exposure for substantive change to occur).

Overall, training, continuing education, agency-based training, and sexual health-based supervision are all methods proposed to prepare student clinicians for working effectively with clients experiencing sexual health concerns (Diambra, Pollard, Gamble & Banks, 2016; Jennings, 2014; McGlasson et al., 2014; Russell, 2012). In one example, Zeglin, Van Dam, and Hergenrather (2017) proposed ten human sexuality counseling competency components to close the gap between client sexual-health distress and clinician preparedness to address sexual health topics. Their domains included Ethical/Professional Behavior, History & Systems, Anatomy/Physiology, Sexual Identity, Sexual Development, Intimacy and Interpersonal Relationships, Pleasure and Sexual Lifestyles, Sexual Functioning, Health/Medical Factors, and Sexual Exploitation (Zeglin, Van Dam, & Hergenrather, 2017). These proposed domains, if integrated into counselor education programs, could help strengthen the attitudes, knowledge, and skills of counselors with the ultimate goal of enhancing competence when addressing sexual health concerns with clients (Zeglin, Van Dam, & Hergenrather, 2017).

Council for Accreditation of Counseling and Related Educational Programs (CACREP)

Another body of standards governing select counselor education programs is the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2016). CACREP outlines program standards and accrediting criteria for counselor training programs across the nation, which includes the learning environment, professional counseling identity, professional practice, evaluation, specialty areas, and doctoral standards. The current standards iterate the importance of counselor training and preparation to best meet client needs in a multicultural society (CACREP, 2016).

Furthermore, under the CACREP umbrella, students and counselors develop and exercise a professional identity encompassing knowledge of roles, responsibilities, and advocacy processes to address social barriers (CACREP, 2016). They understand the systemic, biological, neurological, physiological, and environmental factors that impact human development, functioning, and behavior (CACREP, 2016).

Under the Marriage, Couple, and Family Counseling specialty area, the standards state that counselor education programs with a marriage, couple and family counseling program must address "human sexuality and its effect on couple and family functioning" (CACREP, 2016, p. 31). Additionally, sexual health is addressed under the Rehabilitation Counseling specialty area, indicating that programs must address the "impact of disability on human sexuality" (CACREP, 2016, p. 36). However, sexual health and wellness topics are not addressed in any of the CACREP core standards (Zeglin, Niemela, & Vandenberg, 2019) or within the Clinical Mental Health Counseling specialty, Furthermore, the 8% of CACREP-accredited programs require a sexuality course (Dermer & Bachenberg, 2015) decreases to approximately 6% if Marriage, Couple and Family Counseling programs are excluded (Dermer & Bachenberg, 2015).

Supervision & Consultation

Supervision is an important aspect of counselor training (Bernard & Goodyear, 2019) and creates space for counselors to develop personally and professionally while improving competence (Bradley & Kottler, 2001). In addition to overall enhancements in training, supervision can support clinicians in accurately assessing sexual health concerns and in making informed choices about treatment and preparing counselors to work with clients ethically and competently in regard to sexual issues (Zeglin, Van Dam, &

Hergenrather, 2017). Supervision and consultation, relationships in which guidance and collaboration are fundamental, is a priority when treating clients with sexual health concerns to assess for and mitigate instances of counselor judgement, embarrassment, and anxiety (Buehler, 2017). By working with an experienced supervisor, clinicians can dismantle negative countertransference that may impede therapeutic work (Buehler, 2017). Consequently, supervision has been considered a significant aspect in development in counselor comfort with sexual health topics (Giami & Pacey, 2006; Harris & Hays, 2008).

According to Sanabria and Murray (2018), supervision of counselors addressing sexual health concerns involves various supervision models to ensure counselors are providing comprehensive and ethical care. For example, Ancis and Ladany's (2010) multicultural framework for supervision includes five domains which can be applied to sexual health work: personal development, conceptualization, intervention, process, and evaluation. This model challenges supervisors to ensure supervisees' demonstrate knowledge and self-awareness, understand sexual issues from a sociocultural lens and impact on the client, explore and apply appropriate interventions, discuss sexuality-related work in a meaningful and helpful way, and provide open and honest feedback about the supervisee's development in this area (Sanabria & Marray, 2018).

Supervisors can also use sexuality counseling-based models such as P-LI-SS-IT (Annon, 1977) to support clinical work involving sexual health. According to this model, counselors create a space of Permission (P) to discuss sexual concerns, educate and correct misinformation at the Limited Information (LI) intervention level, provide Specific Suggestions (SS) that may be helpful for the client's sexual concerns, and

administer Intensive Therapy (IT) to address sexual, psychological, and relational issues (Annon, 1977; Sanabria & Marray, 2018).

Although supervision and consultation are helpful in successful sexual health work, it is unlikely that clinicians will develop attitudes and acquire knowledge and skills in general supervision settings; clinicians often need to seek supervision with a specific focus in sexual health (Harris & Hayes, 2008; Miller & Byers, 2008; Russell, 2012). This supervision is not always readily available to students and perpetuates the challenge of addressing sexual health topics competently. Despite this challenge, when available, the opportunity to discuss sexual health topics in supervision increased overall counselor comfort level, feelings of competence, and sex-positive knowledge (Cruz, Greenwald, & Sandill, 2017; Harris & Hayes, 2008; Love & Farber, 2017), suggesting that supervision, knowledge, and training are essential in building clinical self-efficacy for sexual issues (Hipp & Carlson, 2019; Kratochwill & McGivern, 1996) Moreover, current researchers report a need for more of each area overall in counselor supervision (Britton & Bright, 2014).

Sex Therapy

The field of sex therapy developed out of the need to competently address sexual health topics. Nonspecialized clinicians, by definition, lack training and possibly comfort when addressing sexual topics or issues with clients (Buehler, 2017). Thus, sex therapy has become a specialty area of psychotherapy, distinct from general therapeutic work (Binik & Meana, 2009). In its beginning, the foundation of sex therapy was developed around the 1960s though a psychoanalytic lens (Berry, 2012) and flourished following the introduction of specific behavioral techniques presented by Masters and Johnson

(1966, 1970). Helen Singer Kaplan furthered the work of Masters and Johnson by introducing the *human sexual response,* the interlocking nature of desire, arousal, orgasm, and treatment of sexual disorders (1974). The development of the field coincided with the sexual revolution of the 1960s and 1970s, during which sex therapy addressed issues ranging from disorder (deviation from "normal" sexual behavior) to improving sexual experiences of all people (Walker & Robinson, 2012). Sex therapy and therapeutic techniques have since developed through consideration of psychological, biological, and social factors (Berry, 2012).

In the years that followed, clinical sexologists developed a report through the World Health Organization proposing that sex therapy be utilized not only for complicated sexual concerns, but also provided by health professionals that have received specialized training (WHO, 1975, p. 43). This report placed the greatest emphasis on sex therapy compared to the other two components of therapeutic care, education and counseling, as general training and counseling was deemed not sufficient in treating sexual issues (Giami, 2002).

Currently, the practice of sex therapy includes a variety of interventions and integrates psychotherapy and medicine (de Lucena & Abdo, 2017). Various theoretical perspectives are used to treat sexual difficulties and improve overall functioning and wellness of the client (de Lucena & Abdo, 2017). In a study conducted by Melnik and Abdo, patients who received group sex therapy and medication showed improvement in post-treatment scores compared to the group which received medication alone (2005). Researchers presented similar results in a subsequent study with patients experiencing erectile dysfunction (Abdo, Afif-Abdo, & Otani, 2008). Several researchers concluded

that therapeutic work focused on improving sexual issues was critical in alleviating reported patient distress (Abdo, Afif-Abdo, & Otani, 2008; Melnik & Abdo, 2005).

Researchers now call for comprehensive treatment planning of sexual issues, including a variety of professionals to be involved as part of the treatment team such as medical doctors, psychotherapists, physical therapists, and psychiatrists (de Lucena & Abdo, 2017). However, the elaborate and intricate practices of sex therapy, juxtaposed with traditional counselor education and training, are highly discrepant, creating additional challenges for addressing sexual health topics in general clinical practice.

Sexual Health and Clinical Practice

According to Russell (2012), the barrier to addressing sexual health topics with clients is partly due to the lack of training and preparation of counselors, while other researchers claim that this barrier is partly due to negative attitudes and discomfort with discussing sexual health topics (Buehler, 2017; Dermer & Bachenberg, 2015; Dupsoki, 2012; Harris & Hays, 2008; Russell, 2012). To explore these barriers, researchers have complete several studies with other healthcare professionals regarding their comfort level in addressing sexual health concerns, demonstrating similar patterns (e.g. Haboubi & Lincoln, 2003; Kotronoulas, Papadopoulou, & Patiraki, 2009; Lewis & Bor, 1994; Saunamäki, Andersson, & Engström, 2010). However, few studies have been completed with mental health professionals.

One such study (Haboubi and Lincoln, 2003) surveyed 100 medical doctors, nurses, physiotherapists, and occupational therapists on sexual comfort. Ninety percent of respondents reported that addressing sexual health was an important part of providing comprehensive care; however, ninety-four percent of respondents reported that they

would not initiate conversations with patients about sexual health because they did not feel comfortable doing so and lacked self-efficacy in addressing sexual health issues (Haboubi & Lincoln, 2003). In a study completed with nurses, sixty-six percent of nurses reported feeling comfortable with addressing sexual concerns with their patients (Saunamäki, Andersson, & Engström, 2010).

Researchers of a similar study reported that sixty-seven percent of nurses reported feeling comfortable with discussing sexual concerns, of which only forty percent felt the need to do so, while thirty-three percent did not feel comfortable discussing or initiating the dialog (Kotronoulas, Papadopoulou, & Patiraki, 2009). Nurses with less knowledge of sexual health were less likely to address sexual health concerns with their patients (Lewis & Bor, 1994). Despite the available data and statistics regarding various sexual health topics, it remains unclear how often these topics are being discussed within a therapeutic setting and if discussed how they are being addressed among mental health professionals (Russell, 2012).

Similar to the principles of general psychotherapy, effectively addressing sexual issues in clinical practice includes openly discussing sex (in the same way a counselor may address depression or anxiety), psychoeducation, skills training and exercises, conceptualization of the presenting issue in the context of the whole sexual experience (in the same way a clinician may explore the ways depression may impact the client's ability to maintain relationships, for example), and therapeutic interventions that are appropriate and individualized (de Lucena & Abdo, 2017). Despite the fact that general counseling skills can be applied to sexual health issues and the importance of sexual health on mental wellbeing and identity (Anderson, 2013), counselors often continue to avoid or

report experiencing discomfort when addressing sexual health issues with clients (Dupsoki, 2012). Lack of comfort, negative attitudes related to sexual health, and how well a counselor believes they can address sexual health are barriers to providing adequate and ethical counseling related to sexual health topics (Anderson, 2002; Buehler, 2017; Dermer & Bachenberg, 2015; Dupsoki, 2012; Graham & Smith, 1984; Haag, 2008; Harris & Hays, 2008; Lewis & Bor, 1994; Miller & Byers, 2008; Russell, 2012; Weerakoon, Sitharthan, & Skowronsk, 2008)

Clinician's Comfort with Sexual Health

Counselor discomfort with sexual health reinforces negative societal messages about sexuality (Buehler, 2017) and can rupture the therapeutic relationship or prevent clients from receiving the comprehensive care necessary for overall wellness (Buehler, 2017; Cupit, 2010). According to Pukall (2011), clinicians who are not comfortable discussing sexual health topics with clients cannot effectively provide counseling. The definition of sexual comfort was introduced by Graham and Smith (1984) as an integral component in discussing sexual health topics with clients. Graham and Smith (1984) asserted that counselor sexual comfort develops as the counselor's knowledge of sexual health develops. A clinician's lack of comfort addressing sexual health topics could stem from several sources, including lack of knowledge about sexual health, lack of intervention skills, personal traumatic or negative sexual experiences, fear of offending the client, considering sexual health as a taboo topic, minimizing the importance of sexual health, biases about typical or atypical sexual behavior, or apprehension about maintaining appropriateness between the clinician and client (Buehler, 2017; Harris & Hays, 2008; Hipp & Carlson, 2019; Miller & Byers, 2008). Thus, clinicians need to be

trained and prepared to discuss sexual development, behaviors, and experiences with clients effectively (Miller & Byers, 2008). However, Dermer and Bachenberg (2015) reported that counselor comfort with sexual health topics has not changed significantly over the last several decades and that counselors have not demonstrated improvements in their comfort level when addressing sexual health topics with clients.

According to Shindel and Parish (2013), healthcare workers reported that they are expected by the general public to be knowledgeable and willing to discuss sexual concerns, but also reported that they are sometimes met with insensitivity and judgement from professionals when seeking help for sexual issues (Buehler, 2017; Sloan, 2014). This is possibly because counselors (and other healthcare workers): feel uncomfortable discussing sexuality with their clients (Dermer & Bachenberg, 2015; Harboubi & Lincoln, 2003; Stockwell, Walker & Eshleman, 2010), are ill-prepared to integrate sexual health into their practice (Byers, 2011; Ford & Hendrick, 2003; Sloan, 2014), and want additional training on sexual health (Miller & Byers, 2008; 2010). According to Dermer & Bachenberg (2015), a lack of basic knowledge, skills, and attitudes impedes comfortably discussing sexual health issues, especially considering the complexity and diversity across sexual health topics. Additionally, in a study conducted by Harboubi and Lincoln (2003), mental health workers had the lowest comfort level and were the least likely to address sexual health topics with clients across a diverse array of healthcare professions (e.g. medical doctors, nurses, and occupational therapists).

Conversely, Anderson (2002) found that counselors with greater experience in the field reported increased comfort when discussing sexual health with clients. While experience aids in the increase of sexual comfort, *attitudes* towards sexuality and sexual

health were the greatest predictor of sexual comfort (Anderson, 2002), and in this study counselor educators were encouraged to promote positive sexual attitudes and sex-positive training.

In another study, inconsistency was reported among counselors' level of sexual comfort and initiation of sexual health discussions, although counselors who did initiate discussions generally reported a higher level of sexual comfort (LoFrisco, 2013). And while Graham and Smith (1984) indicated that knowledge aided the increase of sexual comfort, interestingly, published results have been mixed regarding the contribution of knowledge to comfort with sexual health, with some researchers suggesting that sexual health knowledge is not significantly related to sexual comfort (Decker, 2010; Ford & Hendrick; 2003; Harris & Hays, 2008) and others reporting a positive correlation between the two factors (Graham & Smith, 1984; Haag, 2008; Weerakoon, Sitharthan, & Skowronsk, 2008).

In addition, clients' level of sexual comfort can add a layer of complexity to this issue. Clients may not initiate discussions themselves due to several factors, including clients perceiving that their clinician is uncomfortable discussing sexual health (Buehler, 2017; Croft & Amussen, 1993). In addition, embarrassment, anxiety, or personal beliefs about the topic may also be a barrier to discussing or initiating dialog about sexual health with clients (Buehler, 2017; Hipp & Carlson, 2019). Therefore, due to client reluctance, if clinicians do not initiate discussions, clients' distress and presenting issues may be left untreated (Buehler, 2017; Hays, 2002; Hipp & Carlson, 2019).

Clinician's Attitudes about Sexual Health

A clinician's attitude about sexual health encompasses the way in which they perceive and respond to sexual health topics and their willingness to address sexual health issues as they present in a therapeutic setting. According to Anderson (2002), a clinician's attitude about sexual health was considered to be the greatest predictor of sexual comfort and in turn, integration of sexual health into clinical practice. And according to Love and Faber (2017), generally open and positive attitudes about sexual health topics as perceived by the client were reported as an agent for therapeutic change and progress and an important aspect of the therapeutic relationship as a whole.

In a study completed by Russell (2012), child and adolescent mental health clinician's attitudes about sexual health, and not their knowledge of sexual health, influenced their interactions and behaviors with clients. The participants included 158 counselors, social workers, art therapists, and direct care workers who completed the Sexuality Attitudes & Beliefs Survey (SABS; Reynolds & Magnan, 2005), a Sexual Health Knowledge (SHK) instrument created by the researchers, and a demographics questionnaire. A statistically significant, negative relationship was calculated (r = -.702) between the degree to which a participant's perceived barriers to addressing sexual health concerns and a participant's sexual health knowledge; the higher a clinician's sexual knowledge, the fewer barriers clinicians perceive to addressing sexual issues with clients. Additionally, a clinician's overall attitude about addressing sexual issues most strongly influenced the likelihood that they would address sexual concerns, as influenced by education, clinician self-reflection, and attitude assessment in regard to sexual health.

According to Russell (2012), counselors place great emphasis on their personal values and beliefs when addressing sexual health topics in place of research-driven training and best practice methods. Buehler (2017) examined negative emotions, experiences, and perceptions as a barrier to addressing sexual health, for example, negative countertransference, counselor judgement, embarrassment, and anxiety might lead to poor interactions with clients and decrease the likelihood of positive therapeutic outcomes. And according to Buehler (2017), these personal biases could negatively impact therapeutic work by imposing unhelpful beliefs and judgment onto the client. Additionally, negative attitudes could be the result of counselors operating in the same sociocultural environment as their clients, such environments that might emphasize hypersexuality or sex-related shame (Sangra, 2016).

Among nursing professionals, nurses with negative attitudes about sex were also less knowledgeable about sexual health in general, and thus less likely to address sexual health issues (McKelvey, Webb, Baldassar, Robinson, & Riley, 1999; Russell, 2012; Webb, 1987). When applied to the counseling profession, Russell (2012) stated that counselors with negative attitudes might project a lack of knowledge and overall inability to address sexual health concerns of clients. And in some cases, mental health professions are likely to exercise avoidance, meaning that they might remain silent in addressing sexual health issues and integrating sexual health into their practice, often placing sexual health outside the scope of their practice (Urry, Chur-Hansen, Khaw (2019).

Thus, for successful integration of sexual health into clinical practice, it is important to assess personal biases and develop sex-positive attitudes (Anderson, 2002; Harris & Hays, 2008; Russell, 2012). However, within the mental health community, sex

has historically been and continues to be a taboo topic associated with negative social messages or scripts, limited knowledge, inadequate safe opportunities to consume accurate information, religious views and practices, ineffective educational programs, and negative experiences associated with sex (Buehler, 2017; Giami, 2002; Russell, 2012, Urry, Chur-Hansen, Khaw, 2019). Each of these factors could color a clinician's attitude and comfort when addressing sexual health concerns and impedes successful integration of sexual health into clinical practice (Buehler, 2017).

Clinician Sexual Health Self-Efficacy

Another barrier to integrating sexual health into therapeutic work with clients is a clinician's perceived self-efficacy in regard to sexual issues. When clinicians believe that a particular subject will challenge their self-efficacy, they are less likely to assess for, address, or intervene when issues related to the topic arise (Dermer & Bachenberg, 2015; Miller & Byers, 2008). Due to lack of research, it is unclear if clinicians in general believe they are competent in addressing sexual health issues (Russell, 2012). However, across a diverse population of healthcare workers, mental healthcare workers (such as counselors and social workers) reported the lowest comfort level with sexual health topics and were the least likely to address sexual health topics with clients due to lack of preparation and training (Harboubi & Lincoln, 2003).

As an example, Miller and Byers (2010) reported that 110 American and Canadian psychologists reported that lack of skill to directly address sexual health issues and lack of accurate information about sexual health concerns ("Skill Self-Efficacy" and "Information Self-Efficacy") led to decreased self-efficacy. In another study, 60% of 188 Canadian psychologists reported that they did not feel comfortable or possess the training

to address sexual health issues (Reissing & Giulio, 2010). In both examples, the clinical sample was unequipped (due to of lack of knowledge, comfort, or both) to discuss sex or sex-relates issues with their clients.

In another study, Harris and Hays (2008) studied 175 members of the American Association for Marriage and Family Therapy on how their education and clinical training, sexual knowledge perceptions, and level of comfort with sexual content influenced their willingness to discuss sex-related concerns with their clients. Harris and Hays (2008) found that through education and supervision, clinicians became more comfortable discussing sexual health topics, and subsequently were more likely to engage in sexual health discussions with their clients. This outcome implies that training and supervision could be vital in the development of sexual health self-efficacy. Harris and Hays (2008) also proposed a four-stage model for supporting clinicians to make internal changes and develop a heightened level of comfort with sexual health topics: self-examination, problem awareness from the client's perspective, increased freedom and comfort in discussing sexual topics, and awareness of new level of comfort with clients' sexual issues.

Moreover, perceived self-efficacy when addressing sexual health topics is also related to the clinician's willingness to initiate discussions about sexual health. In a study conducted by Miller and Byers (2009), the researchers reported that about half of all counselors "always" asked their clients about sex. However, and of note, this information does not reflect the common phenomena of possibly over-reporting comfort levels in regard to sexuality (Buehler, 2017). Additionally, this data highlights that approximately half of the clinician population does not ask about sex as a part of their clinical work due

to lack of self-efficacy in addressing sexual health issues overall (Buehler, 2017). Although there is no specific process for increasing self-efficacy with the topic of sexual health, this process might start by assessing a clinician's anxiety when faced with the challenge of addressing sexual health concerns (Hipp & Carlson, 2019; Ooi, Wan Jaafar & Baba, 2018). Additionally, recommendations for supervision, education, and additional training are vital in the development of self-efficacy for the topic of sexual health (Hipp & Carlson, 2019).

Integrating Sexual Health into Clinical Practice

If clinicians believe they are not versed in a topic area, such as sexual health, they are less likely to assess for sexual health issues and integrate sexual health into their practice (Dermer & Bachenberg, 2015; Miller & Byers, 2008). According to de Lucena and Abdo (2017), assessment of sexual issues must include several components. First, the clinician must conduct a thorough investigation of sexual functioning such as thoughts, feelings, behaviors, and receptivity during sexual activity (Lucena & Abdo, 2017). Then, they must explore possibly comorbidities due to or as a result of sexual issues, hypotheses and possible factors maintaining the distress, clear treatment objectives, and engage in open feedback with the client about treatment plan (Lucena & Abdo, 2017). However, Lucena and Abdo assume that either the clinician or client will initiate dialogs about sex, but it is unclear how a nonspecialized clinician would inquire about or address sexual health topics. For instance, lack of preparedness and discomfort has led to a reluctance with assessing a client's sexual health, despite recognition of its importance (Giami & Pacey, 2006; Nasserzadeh, 2009). To date, only one study has been completed exploring Licensed Professional Counselors (LPC) and how they assess for sexual health

during the intake process (Gregory & Paylo, 2020). In this study, Gregory and Paylo (2020) administered a questionnaire to 939 LPCs to inquire about the importance of, comfort with, and process of assessing a client's sexual history during the intake process. Counselors reported a need to assess for sexual history; however, and consistent with previous research, counselors varied in comfort level with engaging in sexual health discussions (Gregory & Paylo, 2020). Counselors also reported feeling unprepared to initiate sexual health discussions due to lack of training (Gregory & Paylo, 2020).

Although very limited, previous qualitative research on sexual health has discussed how counselors conceptualize sexuality (Mallicoat, 2012), the subjective experiences of counselors providing sexuality counseling (Ng, 2006), and counselor comfort with sexual health and supervisor role (LoFrisco, 2013). Sangra (2016) conducted a qualitative narrative study to address the gap in the literature regarding successful integration of sexual health by interviewing three Canadian counselors about their integration of sexual health and found that integration was linked to the way the counselor conceptualized sexual health, the way in which this influenced their practice and approach to discussing sexual health with their clients, the barriers to addressing sexual health, and methods to addressing barriers (Sangra, 2016). Sangra (2016) also found that the three participants had a broad understanding of sexuality and the importance of sexual health in overall wellbeing, which influenced them to integrate sexual health into their practice. However, active integration of sexual health was also influenced by the issues the client presented, the counselor's perception of the client's experiences, the counselors own personal experience, and his or her development in the realm of sexual health (Sangra, 2016).

Limitations of this study included a small sample size (three) and counselor training that took place in another country (Canada), which may differ from training provided to counselors in the United States. Additionally, Sangra's (2016) participants had at least five years of counseling experience and reported actively practicing sexuality counseling. This distinction may have led to counselors having attitudes and practices that differed from the general clinician population. Thus, the current proposed study will further the research completed by Sangra (2016) by interviewing eight to ten non-specialized counselors about their experiences integrating sexual health into their practice.

Summary

Sexual health is a broad topic area encompassing many facets of physical, psychological and social functioning related to sexuality (Buehler, 2017; Zeglin, Van Dam, & Hergenrather, 2018). It is an area often neglected by counselors for a variety of reasons, including: lack of knowledge (Dermer & Bachenberg, 2015; Graham & Smith, 1984; Haag, 2008; Lewis & Bor, 1994; Weerakoon, Sitharthan, & Skowronsk, 2008), negative personal beliefs and attitudes Anderson, 2002; Buehler, 2017; Dermer & Bachenberg, 2015; Dupsoki, 2012; Harris & Hays, 2008; Russell, 2012), and low self-efficacy (Dermer & Bachenberg, 2015; Miller & Byers, 2008; Russell, 2012), which creates a gap in comprehensive client care (Buehler, 2017; Russell; 2012). These barriers demonstrate a need to shift in the way clinicians conceptualize and treat sexual health; however, little research is available on best practices for equipping counselors and students to address sexual health topics (Sangra, 2016).

With an increase in sexual health-related issues and large percentages of the population reporting difficulties related to sexual functioning (Buehler, 2017; Cleveland Clinic, 2016; Shaeer & Shaeer, 2012) the counseling profession is coming up short in training and preparing clinicians to address the integration of sexual health and counseling practice (Giami & Pacey, 2006; Nasserzadeh, 2009). Furthermore, clients' reluctance to initiate sexual health discussions, paired with lack of training, presents significant treatment planning and diagnostic concerns (Gregory & Paylo, 2020). Given that improved sexual health and functioning has been connected to improved overall well-being, successfully integrating sexual health into clinical practice is necessary to competently and ethically practice counseling (Laumann, Paik, & Rosen, 1999; Tobkin, 2010, Wincze & Weisberg, 2015).

Understanding the experiences of counselors who have already successfully integrated sexual health into their clinical practice creates opportunity for counselors and students to adopt productive and helpful attitudes, behaviors, and skills (Sangra, 2016). At this time, a single, unpublished study has been completed on successful sexual health integration, highlighting a need for a deeper understanding of "what's working" among the clinical community and ultimately improve counselor education and training programs (Sangra, 2016). The present study aims to bridge the gap in the literature by introducing the voices of professional counselors who successfully integrate sexual health into their clinical practice from a phenomenological perspective.

CHAPTER III

Methodology

This study aimed to describe the experiences of clinicians who have integrated sexual health in their practice. Specifically, I focused on experiences of clinicians who have *successfully* included various facets of sexual health in the work that they do with their clients. I utilized the transcendental phenomenological methodology (Moustakas, 1994). This methodology was used to address the following research question: What are the experiences of licensed mental health professionals with integrating sexual health into their work with clients? The components of this chapter are: (a) research design, (b) bracketing, (c) selection of participants, (d) informed consent, (e) data collection, (f) data organization, (g) data analysis, and (h) trustworthiness. This chapter concludes with a summary of the above-mentioned components.

Research Design

According to Creswell and Poth (2018), qualitative research is appropriate when researchers are interested in understanding the contexts in which research participants address various issues. For the present study, understanding the environment and perspectives that contribute to successful integration of sexual health in counseling sessions was necessary for promoting an overall change in the way sexual health is viewed and addressed in training and clinical settings. Therefore, I used a phenomenological qualitative research design to explore the experiences of mental health clinicians' who successfully integrated sexual health into their practice.

Phenomenological qualitative research provides an avenue for researchers to ground themselves in the world and experiences of participants with the intention of

making sense of the phenomena based on the meaning attached by the participants. The goal of phenomenological research is to explore commonalities between personal experiences of participants to achieve a universal essence of *what* was experienced and *how* it was experienced (Creswell & Poth, 2018; Moustakas, 1994). Researchers utilizing the phenomenological approach strive to understand the *essence* of an experience thorough the participants' unique descriptions (Creswell & Poth, 2018).

According to Moustakas (1994), phenomenological knowledge is acquired through understanding of the meaningful connections attached to the descriptions provided by participants within a specific context. Based on this understanding, qualitative phenomenological inquiry was an appropriate and fitting methodology to explore this topic given the lack of available information on how sexual health is incorporated and addressed in the counseling relationship. Additionally, given that behavior and experiences are interconnected, understanding both aspects through the direct account of the participant is essential for meaningful understanding and promoting of change (Moustakas, 1994).

Transcendental Phenomenology

The origins of phenomenological research are rooted in the philosophical work of Edmund Husserl (Creswell & Poth, 2018, Moustakas, 1994). Subsequent writings offered alterative philosophical perspectives; however, all the perspectives shared a common stance: phenomenology is based on the lived experiences of people (van Manen, 2014) and a focus on descriptions of the essences of the experiences as opposed to analyses or explanations (Creswell & Poth, 2018, Moustakas, 1994). Transcendental phenomenology

differs from other phenomenological approaches in that the research is initiated through a transcendental lens, data collection methods, and analysis (Moustakas, 1994).

A unique facet of transcendental phenomenology is the researchers' "fresh" perspective of the participants' experiences that is not clouded by the personal experiences of the researchers themselves (Moustakas, 1994, p. 22/34). This perspective is ensured through an initial process, in which researchers set aside their preconceived understandings and judgements about the phenomena under investigation. Additionally, researchers utilizing the transcendental approach develop a comprehensive picture of an experience through creativity, intuition, as well as understanding underlying dynamics and how specific experiences elicit a variety of cognitive, psychological, physiological, and sensual responses (Moustakas, 1994).

Transcendental phenomenology was selected for this study because its specific features complemented my interest in evoking meaningful descriptions about successfully integrating sexual health with clients, identifying commonalities or themes, and developing an essence of the overall experience (Moustakas, 1994). Through intuition, perception, personal awareness, and reflections, participants had the opportunity to report their authentic experiences free from factual and judgmental overlays, with the goal of creating meaningful information that could inform clinical practice (Moustakas, 1994).

Bracketing

An essential primary step of transcendental phenomenological research is *epoche*, or bracketing, in which a researcher considers his or her personal experience with the phenomenon being discussed (Creswell & Poth, 2018). A primary function of this initial

process was to set aside personal experiences and create space to engage the data without the influence of past knowledge (Creswell & Poth, 2018; Giorgi, 2009). I bracketed my experiences with the transcendental phenomenological approach to limit my personal influence on the present study. Through bracketing my own experiences with the phenomenon being studied, I was able to examine participant responses in a way that was most authentic to each participant's experience while suspending my own judgments (Peoples, 2020; Moustakas, 1994).

In an effort to exercise openness and reflexivity, I now share my experience with the phenomena under study, that is, the successful clinical integration of sexual health. I am a 27-year-old, Pakistani-American woman who was born and raised in Southeast Texas. My initial clinical exposure to sexual health was through an elective course taken during my undergraduate experience at a large, public university in Texas. The course was titled Psychology of Sex and was co-taught by Dr. David Buss and Dr. Cindy Meston, both of whom are pioneers in their respective fields of evolutionary psychology and sexual research. My graduate work was completed at a much smaller, faith-based university. During this time, I obtained a certification in sex therapy though a local training program. This program was not accredited by the American Association of Sexuality Educators, Counselors, and Teachers (AASECT) during my time as a student; however, the coursework did meet the criteria for certification through AASECT if students chose to pursue the certification independently. At this time, I continue to practice as a Certified Sex Therapy candidate, indicating that my coursework for the certification has been completed and that I am under supervision while accruing direct client contact hours. Through the duration of the study, I actively provided counseling

services that included but were not limited to counseling for sex-related issues. I also supervised several counselors during their clinical work, which at times included sexual health topics. My interest in sexual health is a culmination of an insightful and engaging undergraduate course and cultural practices that often overlook and neglect conversations about sex within our community.

Discussions with colleagues and other licensed professionals furthered my interest in this topic, which become the focus of my dissertation. I have been deeply intrigued by the reactions of clinicians in the years I have practiced sex therapy. My interest in this phenomenon was often met with surprise and many subsequent questions from clinicians wondering how I began this work and how to talk about sex with their clients. In addition to bracketing prior to the research study, I maintained a journal throughout the course of the data collection process to ensure I was maintaining distance between the data and myself to prevent personal influence during the data analysis process.

Finally, I journaled throughout the course of the data collection and analyzation process, I maintained a dairy in which I documented my personal experiences before, during, and after each interview to ensure I was not coloring the participants experiences with my own judgment and experiences. I made note of my non-verbal behaviors such as nodding and smiling to minimize the influence of my actions of the participants responses. After each reflection entry, I make subtle changes to my own demeanor to ensure I was engaged while suspended my personal perspectives.

Participants

Recruitment

Alignment of the sample with the research topic of interest is vital to generate data that is rich and relative. After I received approval from the Sam Houston State University's Institutional Review Board (IRB), I distributed recruitment social media posts that provided an overview of the study, explained the purpose, sampling criteria, participant time commitment, and my contact information. Additionally, professional contacts and participants were asked to share information regarding the study to potential participants. For initial contacts made on social media platforms, I requested that potential participants provide their email address and then contacted them through an encrypted email or directly sent the prospective participant an encrypted email upon receiving their contact information through social media.

Participants were selected using purposeful sampling methods to ensure that sample participants were able to provide quality data to inform the research phenomenon (Creswell & Poth, 2018). Criterion sampling included seeking participants that meet a specific, predetermined set of criteria (Creswell & Poth, 2018). Given that the phenomenon that was studied is integration of sexual health in counseling, I was able to select participants who were able to speak about their experience of incorporating sexual heath in their practice successfully. Through criterion sampling, I ensured that the participants were all active licensed professionals who have experienced the same phenomena and that the similarity of the base criteria would aid in the saturation process (Creswell & Poth, 2018).

In addition to criterion sampling, I also utilized snowball sampling through those who agreed to participate in the study. This method included asking initial participants of the study to provide information and refer other potential participants to the study (Crewell & Poth, 2018). Additionally, at the conclusion of each interview, initial participants were asked to identify others that could provide rich data related to the topic and inform those identified to contact the researcher through email if interested.

Given that one phenomenon, successful integration of sexual health, was explored in this study, I used the guidelines of Creswell and Poth (2018) recommending around 10 to 12 participants. The study completed with a total of 11 participants, which was the point of saturation (the point at which no new information was being collected from participant). According to Peoples (2020), in qualitative research, the point of saturation is more important than a projected sample size, which provided justification to conclude data collection with 11 participants.

Screening Criteria

During the initial email correspondence, screening questions were provided to each potential participant. I asked all potential participants to review the list of criteria to ensure eligibility for participation in this study. The criteria included full licensure status in the participant's respective states as a Licensed Professional Counselor or equivalent (a professional counselor who has attained full licensure status following the completion of a supervised internship or associateship in their respective state), active engagement in their practice for at least one year under full licensure status, successful integration of sexual health in the work that was being done with clients, nonspecialized in sex-related topics, and a single licensure.

For clarification, sexual health was defined in the email as any physical, emotional, mental, social, and relational aspects of sexual well-being, sexuality, relationships, or sexual experiences. Nonspecialized in sex-related topics was defined as a practice in which the clinician has not received formal training beyond their graduate education for sex-related concerns (such as a sex therapy certification), except for training limited to continuing education or self-education (books, podcasts, journal articles, etc.). Successful integration of sexual health was defined as the clinician's ability to initiate discussions about sex or sex related topics, feeling comfortable when discussing sex or sex-related concerns with clients, and willingness to explore and address sex related concerns or topics with clients when it comes up. I screened for these components by asking the following questions prior to scheduling the interview: a) Are you willing to initiate discussions about sex or sex-related topics with your clients? b) Do you feel comfortable discussing sex or sex-related topics with your clients? and c) Are you willing to explore and address sex-related concerns or topics with clients when it comes up? A response of "yes" to each of the above questions (a, b, and c) determined successful integration of sexual health.

Next, participants were asked to report "yes" or "no" to the following questions: a) Are you a Licensed Professional Counselor? (or equivalent), b) Have you been in practice for at least one full year as a fully Licensed Professional Counselor? (or equivalent), c) Do you have any sex or sex-related specialty training or certifications?, d) Do you hold multiple licensures? Based on the answers provided, potential participants who met the criteria were invited to schedule a time for the interview. Those who did not meet the criteria for the study were informed and did not participate further.

For participants who met the criteria for the study and wished to continue with the study, a date and time for the interview was collaboratively determined. An email reminder with virtual meeting links was sent to each participant at least 24-hours prior to their scheduled interview time, along with the informed consent documents for the participant to review. All interviews were conducted through Zoom, a secure online platform with a personal meeting ID and password for additional protection and recorded for data analysis.

Informed Consent

Participants who responded and scheduled a date and time with me were sent a digital copy of the informed consent to review along with the virtual meeting link. During the scheduled interview time, I reviewed each of the components of the human-subjects informed consent form and asked for the participants' verbal consent to record the interview, as well as their consent to participate in the research study. I implemented Sam Houston State University's IRB human protections guidelines and informed participants that their information would remain protected, as well as discussed confidentiality procedures, possible threats to confidentiality, and steps taken to maintain their privacy. Participants were informed of the possible emotional risks that could arise during the course of the interview and that they could withdraw from the study at any point without any consequences. Finally, participants were given the opportunity to ask questions or seek clarity if needed. Once the informed consent was reviewed, I obtained verbal consent to begin recording. I then obtained verbal consent to participate in the interview process and conducted the semi-structured interview. A digital copy of the recording and

the transcription of each participant's interview was stored on a secure external hard drive. This folder was password protected and was only accessible to me.

Data Collection

A demographic questionnaire (Appendix C) included the following: a) What is the title of your professional license? b) What state are you licensed in?, c) How many years have you been licensed fully?, d) What are your specialty areas (if any)?, e) What is/are your current practice setting?, f) What setting(s) did you complete your training in?, and g) What is your ethnicity?

Semi-structured interview questions were the primary data collection method for the study. Semi-structured interviews were selected so that relevant questions could be asked while allowing participants to deviate from the questions to discuss other information that were relevant to the phenomena or experience (Peoples, 2020). The interview process was interactive and the researcher used open-ended questions to evoke the participants full experience of the phenomena (Moustakas, 1994). The interview questions were developed prior to the interviews in consultation with the existing literature. Researchers have reported barriers to conversations regarding sex and sex-related topics due to general discomfort, personal attitudes or beliefs, and lack of knowledge, education, and training. Consequently, the questions asked to participants of this study were intended to elicit rich, descriptive information regarding the *success* of clinicians with sex related conversations with clients. The following questions were asked to each participant:

1. What education or training, if any, have you had regarding sex, sexual health, sexuality or even talking to your clients about sex (Cruz, Greenwald, & Sandil, 2017)?
2. What does successful integration of sexual health, sexual topics or sexuality into counseling mean to you?
3. Tell me about your experience with discussing sexual topics with your clients
4. What steps have you taken to improve your experience of discussing or addressing sexual concern with clients?
5. What factors do you believe have had the biggest impact on your ability to discuss sex or sex related topics with your clients?
6. Sex positive is defined as having or promoting an open, tolerant, or progressive attitude towards sex and sexuality. On a spectrum from sex negative to sex positive (1-10), where would you place yourself today? Has that position changed or shifted over time? If so, how has it changed? (Cruz, Greenwald, & Sandil, 2017)
7. What challenges, if any, have you or do you continue to face as you have conversations about sex with your clients?
8. Based on your experiences, what feedback or information do you believe is helpful for counselor training, education, and preparation?

After gathering demographic data, I conducted the semi-structured interviews online through Zoom, a confidential audio and video platform. To maximize the participants' confidentiality, a private Zoom meeting with password protection was used. Benefits of web-based interviews included lower overall cost and time efficiency for the

researcher and comfort, space, and time flexibility for the participant (Creswell & Poth, 2018). Participants were made aware that their interviews would be audio recorded prior to the interview and were asked to agree to this condition prior to the start of the interview.

Data was collected from a total of 11 participants. Each interview lasted approximately 30 to 45 minutes. Follow up questions were asked as necessary to collect as much data from the participant as possible. Upon the completion of each interview(s), the audio recordings were transcribed using a professional, HIPAA compliant transcription service. The transcriptions and audio recording files are secured in a password protected file on a password-protected external hard drive that is locked and stored away. The audio files was destroyed following the defense and acceptance of this dissertation and transcripts were retained in the password protected file.

Following each interview, participants were asked if they would like to participate in the member checking process. This process was described as making additions, modifications, and removals to the interview transcription most appropriately capture the participant's experience. A total of 8 out of 11 participants engaged in the member checking process; however, no major changes were made in the transcriptions through member checking. Participants who agreed to be a part of the member checking process received an encrypted email with the transcription. They were asked to make additions, modifications, and removals as needed, and then return the updated transcription to the researcher.

Data Analysis

According to Creswell and Poth (2018), data analysis in phenomenological qualitative research includes a series of steps, including data organization, identifying and condensing themes, and representing the data effectively. I analyzed the data collected in this study using Moustakas's (1994) modification of van Kaam's (1959, 1966) method of analysis. This process contained seven steps requiring the complete transcript of each participant (Moustakas, 1994).

1. The first step of the process was denoted as *Listing and Preliminary Grouping*, which involved horizontalization of significant statements. I developed a list of "every expression relevant to the experience" using each transcription (Moustakas, 1994).
2. Second, I completed the *Reduction and Elimination* process by reducing the data to meaning units or invariant constituents. I did this by answering two questions for each statement or quote identified in the first step. The questions proposed by Moustakas (1994) were:
    a. "Does it contain a moment of the experience that is a necessary and sufficient constituent for understanding it?"
    b. "Is it possible to abstract and label it?"

    If "no" was answered to either of the above questions, the statement was removed along with vague, overlapping, or repetitive expressions leaving the invariant constituents (Moustakas, 1994).
3. Third, the invariant constituents were *clustered* and *thematized*. This process included grouping the invariant constituents from step two into themes based on

relevancy to one another. The groups were then given a thematic label (Moustakas, 1994).

4. The fourth step was *Final Identification of the Invariant Constituents and Themes by Application: Validation*. This step involved reviewing each invariant constituent and theme against the data from which it was derived. The purpose of this step was to ensure the themes were representative of the participants' experience (Moustakas, 1994).
5. For the fifth step, I created *Individual Textural Descriptions* for the experience by using verbatim quotes and excerpts from each participant.
6. This was followed by step six, in which I created *Individual Structural Descriptions* for each participant. This step involved the use of *Imaginative Variation* (seeing possible meanings) to explore connections between what the participants had reported (Moustakas, 1994).
7. For the seventh and final step, I created a *Textural-Structural Description* for each participant. To do this, I developed composite textural descriptions by outlining themes from each participant to highlight prominent and recurring themes. Additionally, I developed compositive structural descriptions to examine various connections across participants. This helped me explore which elements influenced and contributed to their experience of the phenomena the most. I merged the textural and structural composites to develop the textural-structural description, which comprehensively summarized the phenomena (Moustakas, 1994).

Credibility

To ensure this study was credible (i.e. trustworthy) and to decrease threats to validity, respondent validation or member checking was implemented. This process included gathering feedback about the data collected from the participants themselves. Member checking is an effective method to limit the likelihood that data is misunderstood or misrepresented by the researcher (Peoples, 2020). Extending the opportunity for participants to clarify his or her experiences and the meaning attached to the experience also decreased the likelihood of researcher biases influencing the data. Throughout the interview process, I checked in with participants to ensure that I captured an accurate account of their experience, which was not clouded by my own judgements or biases. I also provided participants with a copy of their transcriptions to make modifications as needed (Maxwell, 2013).

Transferability

Transferability describes the extent to which results and findings from a study can be applied to other similar populations, groups, or settings (Lincoln & Guba, 1985). The demographic questionnaire and semi-structured interview were developed to elicit information about not only the participants' experience, but also information regarding the context in which they practice, training, education experience (or lack thereof), and factors which might influence their ability to successfully integrate sexual health into their work with clients. The responses to these questions provided insight on various contexts and depth of information, which could ultimately inform practice in various settings, among specific clinical populations, and training programs, thereby increasing transferability of findings.

Thick Descriptions

Thick descriptions, sometimes called rich descriptions (Peoples, 2020), refer to comprehensive details regarding the phenomena, such as context, emotions, feelings, voices, actions, etc. (Denzin, 2001). This is consistent with Moustakas's (1994) emphasis on gathering a holistic "picture" of the experience, encompassing feelings, thoughts, perceptions, and sensory information. Moustakas (1994) stressed the importance of asking questions that target the *experience*, implying a more holistic view, instead of perceptions or thoughts alone, which potentially reduce responses to a cognitive level. Thus, all interview questions were developed to elicit responses about the experience as a whole. Additionally, during the data analysis process, I used direct quotes to highlight and capture the integrity and vitality of each individual's story.

Dependability

A detailed review of this research study and process was followed and reported to ensure dependability of the study. Replicating the study by repeating the steps of this research should produce comparable findings if the same phenomena within a similar context is researched. A detailed process including each step of the study is provided in this chapter.

Summary

This phenomenological study was conducted to understand the successful experiences of clinicians navigating conversations about sex and sex-related topics with their clients. I used semi-structured interviews to collect data from 11 licensed clinicians. The data was transcribed and analyzed to develop themes and descriptions and ultimately

create an interpretation of the lived experiences of licensed professionals with the phenomena. This process was conducted through the methods outlined by Moustakas (1994) as presented by Creswell & Poth (2018). Several methods were implemented to reduce threats to validity. The results of this study are presented in the following chapter.

CHAPTER IV

Results

The purpose of this study was to the described the lived experiences of professional counselors who successfully integrate sexual health into their clinical practice. Specifically, I explored professional counselors' attitudes, sexual identity development, and their roles as counselors addressing sexual health, sex, and sexuality topics. This study further explored the personal and professional details that led the counselors to practice comfortably and competently in their respective roles.

Data were collected over a period of two weeks through eleven semi-structured interviews, including a verbal demographic questionnaire (Appendix C). Field notes were collected before, during, and after each interview to bracket and develop insights about the essence of the participants' experience. Each of the interviews was conducted over Zoom, a HIPAA compliant audio-visual platform. Through this method, I was able to add a layer of safety in response to the COVID-19 pandemic. The interviews were audio recorded and lasted 30 to 45 minutes. Each of the interviews were transcribed using a HIPAA compliant transcription service. The transcripts were reviewed again prior to the data analysis process. Transcription documents were shared with the participants who agreed to partake in member checking. These participants reviewed the transcript for verification and accuracy. A table outlining each participant's pseudonym, gender, licensure type and state, specialty areas, current practice setting, and training setting can be found in Appendix D.

A transcendental phenomenological approach was used to outline the methodology for this study and data was analyzed using Moustakas's (1994)

modification of van Kaam's (1959, 1966) method of analysis. Data analysis began by removing excess language and filler statements from the transcriptions. Salient descriptions and significant statements were identified (horizontalization) and entered into a document. Significant statements were color coded and grouped together into themes. Then a description of the experience was developed and supported by direct quotes from the participants, many of which are included below. These textural and structural descriptions were combined to infer an overall essence of the experience (Creswell & Poth, 2018).

Participant Demographics

At the start of each interview, participants were asked to provide verbal consent to participate in the study (Appendix A) and respond to a series of demographic questions (Appendix C). The demographic questions addressed licensure type, state of licensure, gender, years in practice, specialty areas, current practice setting, and the setting in which the participants received their training. Participants' experiences with counseling ranged from 1 to 26 years of experience. Six participants identified as female, and five participants identified as male. All of the participants were Licensed Professional Counselors. Two participants reported working towards a second license (still in progress) and two were pursuing a doctorate in a counseling related field. Regarding location, ten of the participants were licensed in Texas and one participant was licensed in New Jersey. One Texas participant reported that she formally carried a dual licensure status in both Washington and Texas; however, at the time of the interview, she was only licensed in Texas.

Participant Profiles

All interviewed participants met the inclusion criteria prior to the study. I collected data until saturation was successfully reached, leading to 11 total participants. A brief summary of each participant is provided below (see Appendix D for summary table).

Participant #1. Samantha identified as a Caucasian female and a Licensed Professional Counselor in the state of Texas. She had been practicing as a fully licensed therapist for one and a half years and reported that her specialty is working with couples and the LGBT+ community. Although she currently works in a private practice training, Samantha was trained in private practice, a domestic violence crisis center, and a psychiatric hospital.

Participant #2. Solo identified as a Caucasian male and is a Licensed Professional Counselor in the state of New Jersey. He reported practicing as a fully licensed therapist for 15 years after several years of practicing hypnosis before obtaining his license. He reported specializing in work with adolescents and families at the time of the interview. Although he currently works in a private practice setting, he was trained in a hospital and school setting. Solo also teaches Introduction to Psychology at a local college.

Participant #3. Scilia identified as a Hispanic female and a Licensed Professional Counselor in the states of Texas. She reported practicing as a fully licensed therapist for two years and working predominantly with mothers, women, and interpersonal relationships within a faith-based agency setting. She completed her training in both a private practice and hospital setting prior to becoming fully licensed.

Participant #4. Taylor identified as a Caucasian male and a Licensed Professional Counselor Supervisor in the state of Texas. Taylor has been a fully licensed therapist for 15 years and has predominantly worked with individuals and families within the Juvenile Justice program. He also reported an interest in forensics. Taylor currently practices and supervises counselors in an outpatient community mental health agency and was trained in a nonprofit community mental health setting. He also reported being a part of the LGBT+ community, which has influenced his work as a clinician and supervisor.

Participant #5. Fredrick identified as an African American male and a Licensed Professional Counselor in the state of Texas. Fredrick has been practicing as a fully licensed therapist for one year and reported that he does not have any specialty areas. Most recently, he was practicing in a private practice and psychiatric hospital setting; however, he accepted a counselor educator position in another state and plans to seek licensure there while maintaining a Texas license. He reported receiving his training in a crisis center and agency setting.

Participant #6. Mark identified as a Caucasian male and a Licensed Professional Counselor in Texas. Mark has been practicing as a fully licensed therapist for four and a half years. He worked in a private practice setting treating couples at the time of the interview; however, he reported that he was trained in a variety of settings, including an inpatient psychiatric hospital and crisis center. In addition to counseling, Mark also provides private practice consultation to other therapists.

Participant #7. Angela identified as a Caucasian female and a Licensed Professional Counselor in the state of Texas. She had been practicing as a fully licensed therapist for one and a half years in a private practice and hospital setting. She primarily

worked with couples and was trained in a variety of settings including hospital support groups, private practice, intensive outpatient programs, and an inpatient hospital setting.

Participant #8. Hannah identified as a Caucasian female and a Licensed Professional Counselor in Texas. She both trained and practiced in a private practice setting and was fully licensed for 26 years at the time of the interview. Her primary specialty areas include anxiety and couples counseling.

Participant #9. Zayn identified as a biracial male, stating he was half African American and half Caucasian. He is a Licensed Professional Counselor in the state of Texas and has been fully licensed for one and a half years. He reported that his specialty area was financial counseling, focusing on the overlap between emotional health, spiritual health, and financial health. Zayn is also pursuing a doctorate in a counselor education and works at a faith-based group practice. He completed his training in both a private practice and community mental health training facility.

Participant #10. Dorian identified as a Black American female and a Licensed Professional Counselor. She had been fully licensed in the state of Texas for two years. Her specialty areas include telehealth and interpersonal relationships within a private practice setting. She was trained in a group practice setting, private practice, local jail, and hospital setting.

Participant #11. Emma identified as a Caucasian female and a Licensed Professional Counselor. Emma currently lives in Australia; however, she is licensed in the state of Texas. She was formally licensed in the state of Washington. Emma reported that she was fully licensed for 22 years and predominantly treats children and families

within the welfare system. In addition to being a licensed counselor, Emma is also a program implementation supervisor.

Emerged Themes

The research question that this study addressed was: What are the experiences of counselors who have successfully integrated sexual health into their work with clients? The interview questions were as follows (Appendix B):

1. What education or training, if any, have you had regarding sex, sexual health, sexuality or even talking to your clients about sex (Cruz, Greenwald, & Sandil, 2017)?
2. What does successful integration of sexual health, sexual topics or sexuality into counseling mean to you?
3. Tell me about your experience with discussing sexual topics with your clients
4. What steps have you taken to improve your experience of discussing or addressing sexual concern with clients?
5. What factors do you believe have had the biggest impact on your ability to discuss sex or sex related topics with your clients?
6. Sex positive is defined as having or promoting an open, tolerant, or progressive attitude towards sex and sexuality. On a spectrum from sex negative to sex positive (1-10), where would you place yourself today? Has that position changed or shifted over time? If so, how has it changed? (Cruz, Greenwald, & Sandil, 2017)
7. What challenges, if any, have you or do you continue to face as you have conversations about sex with your clients?

8. Based on your experiences, what feedback or information do you believe is helpful for counselor training, education, and preparation?

Themes Endorsed by Participants

Figure 1 represents the themes endorsed by participants, while Table 1 includes the themes with corresponding definitions:

Figure 1

Themes Endorsed by Participants Related to Sexual Health

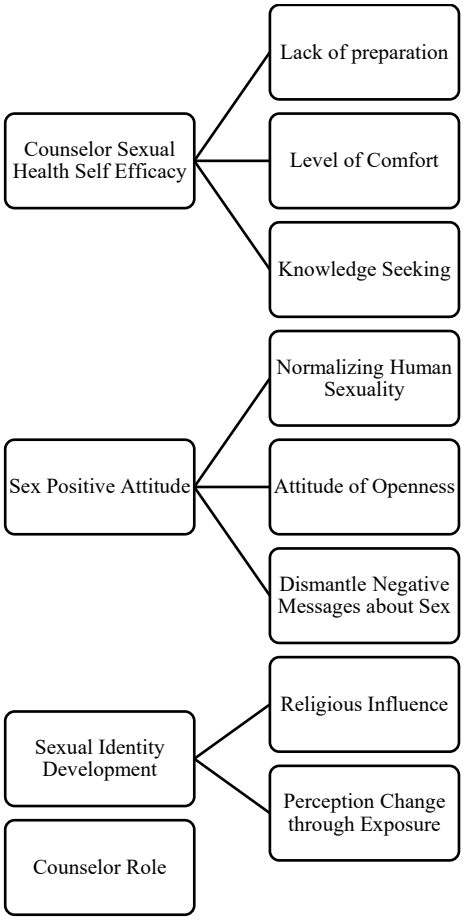


Table 1

Summary of Themes related to Counselors' Experience of Integrating Sexual Health

Theme	Description of Theme
Counselor Sexual Health Self Efficacy	
Lack of preparation	Participants reported feeling underprepared to address sexual health issues
Level of comfort	Participants expressed feeling comfortable with addressing sexual health issues and initiating sexual health discussions
Knowledge seeking	Participants actively sought out information to improve their practice and sexual health competency
Sex Positive Attitude	
Normalizing human sexuality	Participants engaged in normalizing human sexuality for their clients by indicating that it was a part of the human experience
Attitude of openness	Participants maintained an attitude of openness with their clients by welcoming all conversations related to sex
Dismantle negative messages about sex	Participants actively educated clients on accurate information related to sex and sexual health
Sexual Identity Development	
Religious influence	Participants described their personal and professional experiences navigating sexual health and religion
Perception change through exposure	Participants indicated a change in their beliefs through personal and professional exposure to sexual health related experiences
Counselor Role	

Counselor Sexual Health Self-Efficacy

Level of Comfort. The counselors in this study expressed their level of comfort when it came to talking about sex with their clients. Fredrick discussed his awareness of how sexual health discussions can breed discomfort for clients and his role in addressing this when he stated:

> If, um, I'm not comfortable talking about sex, then they aren't going to be comfortable talking about sex. And if sexual concerns are one of the things that they're bringing in, whether it's like a sex addiction or, um, just not feeling fulfilled in their marriage, um, or in their sex life, then they're probably going to stop coming to counseling and that's going to really frustrate them. And then that's probably going to discourage them from coming to counseling in the future as well. And so I think that we as counselors need to have, um, a better just overall awareness being more open and honest about sexual concerns and letting our clients know upfront that this is a topic that if they're wanting to talk about, um, we, as counselors will provide the space for them to talk about it.

Like Fredrick, Patrick also acknowledged the importance of being comfortable is in order to address issues when working with couples:

> I began specializing in couples therapy about two years ago, and it's really a core component of relationships, marital relationships, and other forms of long-term intimate partnerships. Um, and as such, it's important that I'm comfortable talking about it and bringing it up and being able to help overcome issues and difficulties that couples might face in that regard.

Each of the participants reported feeling comfortable talking about sex with their clients. Samantha clearly states, "maybe it's kind of my personality but talking about sex has never been an uncomfortable thing." Like Samantha, Solo also reported a longstanding level of comfort when discussing sex:

> I've been around, my sex life. I have to say that its pretty good. Over the years, it's been varied. I've experimented in a lot of different areas. There's very, very little

> that a client could tell me that's going to shock me or surprise me or that I haven't even thought about or tried at one time or another. So I always feel comfortable talking about it. I have no issue. I have no discomfort. I have zero discomfort, that I can think of anyway, in addressing sexual issues with clients. I mean, I try to be as aware of their issues as I can. I try to be as sensitive.

Ella described her level of comfort by explaining how she reacts to client disclosures and her overall attitude about sexual health:

> I would say that I think I'm pretty hard to shock. I'm not very, I'm, I'm just not very shockable. And, the areas where I have judgment around sexual activity are very limited and they would include, feeling drawn to sexual activity with people who are too young to consent or, I mean, those are the areas around which I have judgments and would feel a need to report that type of sexual activity. But as long as it's legal and everybody's consenting, really, I feel pretty comfortable with anything people choose to share with me around that area.

The counselor's level of comfort was not always reported as innate. Two participants discussed how their childhood experiences may have led to their level of comfort in talking about sex. For example, Angela states:

> I already felt very comfortable talking about sex before that. And in fact, I've always kind of said that what I want to do is become a certified sex therapist. Um, I haven't done that training yet, but I am, that is kind of my end goal, my ultimate goal when, um, when I kind of get to my dream job, that is what I would like to do. So, I've already had that kind of comfort. My upbringing, my mom was

> always very open talking about sex with my sisters and I am one of four daughters. Um, and, and so, you know, we always, always talked about it.

Similarly, Hannah reported:

> I'm very open in discussing anything about their sexuality, but sometimes they're not. I guess I've just always been very open. I mean, I was just kind of an open person. I'm the second oldest of eight kids. And so, um, my parents did not talk about sex, but obviously that was happening. But I felt like I needed to talk to my younger siblings about it even then when I was growing up, you know, because I thought, well, I know mom and dad aren't talking to you about it. So I would talk to them. I don't know. I've just always been pretty open about everything.

Lack of Preparation. While each of the 11 participants discussed their level of comfort with sex, 10 out of 11 participants discussed a lack of formal preparation for addressing sexual health when working with clients. Patrick stated:

> I definitely think that there's a, a huge blow and a lack of education. I think that in grad school, um, even post-graduate, unless you seek a specialty, um, there's really just a lack of that information. Um, you know, and it's not something that we should be shying away from. I think we should be much more upfront about it and I think that our graduate schools or professors can do a better job of integrating that into just the education. Right? They don't, you know, we, we learned a little bit about cognitive therapy. We learn a little bit about Gestalt. It's like, okay, why don't we talk a little bit about sexual health and integration?

Some participants, such as Dorian stated that she did not receive any exposure to sexual health in her graduate program:

> I don't remember having any training. I don't think we had a class that was like an option for that. Like as far as, uh, elective or something, I don't think my school had an option for sexual health unless I missed it or maybe they have it now. I wasn't able to get it.

Similar to Dorian, Samantha reported in regard to her graduate coursework, "Nothing, nothing that was sex therapy focused or sex counseling focus. I've never had intentionally focused training." This was again reiterated by Solo, who said, "I don't have any formal training other than some CEUs that I've taken over the years myself."

While some participants reported having no training or preparation about sexual health, four of ten participants reported that they received either undergraduate or graduate training; however, they felt that the training was insufficient. For example, Fredrick did not realize that his training was not adequate until he began to address sexual health with clients in practice:

> I had one class in my master's program about sexual concerns. Um, I felt that it did a decent job. Um, we talked about sex. We talked about how we would approach the conversation of sex with our, um, clients. We talked about like sexual dysfunctions and things like that. At the time I thought it was adequate. Once I got into practice, I realized that it didn't do a very good job, really preparing me for having these sexual conversations.

Hannah stated that her graduate counseling program did not prepare her to address sexual health issues; however, she was exposed to sexual health through her undergraduate training:

> I actually in undergrad I took, um, human sexuality twice, once in the psychology department and once in the, um, health department just, and I got two different credits for it. But in graduate school, there was not anything that I took or remember about human sexuality.

One participant, Taylor, even discussed possible recommendations for training programs to sufficiently prepare counselors to address sexual health:

> I think during our training, you know, we need more in the coursework. Not only to discuss whether we could or could not treat those clients, but as to, um, more education on how we might treat a client with a sexual problem.

Fredrick further discussed the consequence of lack of preparation, stating:

> I think a lot of the time, counselors are a lot more passive about it and when the topic comes up, um, it's like, "okay, moving on". There's just not as much, what's the word that I'm looking for, openness, to talking about sex as there probably should be.

Zayn, on the other hand, referred to the lack of training as part of the counselor training experience:

> Here's the thing, no matter what you do in the classroom is never going to prepare you for what you're going to experience with the client. It's just not how it is. Yes. We read the books, we know the theories, we do things. Um, but being in that room with that, the client is an experience all in and of itself.

Knowledge Seeking. Given the lack of formal training and preparation, each of the 11 participants demonstrated their willingness to seek out knowledge to improve their

competency level. The participants utilized various methods to increase their knowledge. Scilia stated:

> I sort of reached out to other counselors that, you know, some of them are specialized in sexual, like sex therapy or just sexual health and just kind of hearing how they normalize, how they normalize talking about it.

Patrick also expressed talking to others to increase his sexual health competency by stating, “I've joined groups and consultations that are very centered on being sex positive.” Other counselors reported self-education methods to improve their competency. For example, Zayn reported:

> I teach myself, um, I read two to three books a week on different topics, such as cancer, physical health, sexual health, sexual energy, um, really diverse readings. And so the more you read, the more you expand your mind, the more expanded your knowledge, the more you can integrate things. And so for me, you know, sexuality is a part of that. So understanding through different philosophies, through different schools of thought and really through different experiences of people. Um, it's really cool when you can look at, you know, a lot of people just think of sex as the physical, but when you look at it through the lens of the emotional and the spiritual, right. The intellectual, right. The fact that when you have sex with someone, you create new neurons- neurogenesis, right. It helps with the neuroplasticity of your brain.

Dorian also expressed that reading books provided her with more insight, while also seeking out sexual health related continuing education:

> So like when it comes to getting educated about like sex work and, um, different communities and open lifestyles, reading books, like *The Ethical Slut*, was such an eye opening book, you know, like that kind of thing was just trying to personally educate myself, uh, was as part of it. But then also, like I said, I try to physically seek out those types of continuing education credits and stuff. So I can really get an understanding from a technical point.

While most of the participants discussed a general desire to seek more knowledge, counselors also expressed being motivated by a clinical experience. Ella stated:

> There was a family that I worked with in the agency that I was part of early on that identified as poly and, and I was still, I mean, I was maybe two or three years into my career. I was much less, I identified as agnostic and was, had really moved away from the philosophical orientation of my youth, but it still was like completely new to me to work with clients who identified as being part of those populations. And so, it was something that I started really kind of learning about in order to be able to support them appropriately. And it's something I sought consultation around and read about, all those kinds of things.

Sex Positive Attitude

Normalization of Human Sexuality. Professional counselors maintained a sex positive attitude by normalizing human sexuality for their clients. Samantha stated, "I think that just as much as we ask someone about their mood, we should ask them about how their sex life is going." Scilia reinforced this with clients, particularly when she noticed sex was an "off the table" topic:

> I see people of different ethnicities and people of certain ethnicities are definitely okay talking about sex, talking about certain topics. When I talk to other people of a certain ethnicity, particularly with the ones that come to mind are Hispanic. It's a very taboo topic, so it's very taboo to talk. And one of the fun parts is, um, I've noticed too throughout my time of being fully licensed is getting to normalize that, getting to sit at least telling them that this is a safe, safe space to talk about it and that its not going to get talked about it outside of the counseling session.

Fredrick also discussed the taboo nature of sexual health and the role of counselor the normalizing process:

> Being open and honest about sexuality with your clients is important. Making sure that they feel like I'm a safe space for them to talk about their sexual concerns. Because sex, for whatever reason in our society, is very taboo. So if, um, I'm not comfortable talking about sex, then they aren't going to be comfortable talking about sex.

Counselors normalized sexual health by discussing sexual health from the start of treatment. Sex positive counselors regularly initiated and engaged sex related discussions. Patrick reported feeling surprised that this approach was out of the norm of clinical practice for most counselors when he stated,

> It always surprises me when I asked my couples about sex in intake and they tell me that I'm the first therapist that just directly asked them about, um, their sex lives. And for me, you know, that's something that we as therapists are kind of missing, um, because it is so important to, to most relationships. And I'm not going to say it's important to every relationship. Um, but for most couples in a

long-term intimate partnership, sex is very important to them. So for counselors and therapists, not to be bringing it up, um, I think is a disservice.

Counselors were aware that sexual health discussions were often not initiated by the client or other therapists. Therefore, they initiated the conversations about sex to normalize the experience of speaking about it later in treatment. Patrick stated,

> I have candid conversations with clients about, um, their sex lives, their own individual sexual health as well, um, as well as being able to facilitate those conversations within the couple dynamic. Um, so it's really important just to, you know, for me to initiate that conversation and just set a safe setting in which couples can share their experiences, um, in regard to sex and sexuality.

Similarly, Angela stated:

> I typically am the one to bring it up. I let my clients know early on that it's something that I feel very comfortable talking about. And so if it's something that they're interested in discussing, I kind of opened the door for that and just let them know that, that if there's anything that they wanted to talk about, and, um, but just kind of letting them know, I understand that this can be a very important topic for people, and it also can be a really taboo topic that people don't feel like very comfortable talking about and just want to let them know kind of off the bat. I'm very comfortable talking about it. I, I kind of opened that door to you. If this is something that you want to discuss, I am, I'm here to listen. Um, I certainly might not have all of the answers that this is the safe place for you to be able to talk about it.

Through initiating conversations, counselors also educated clients on the importance of integrating sexual health into their work. Scilia stated,

> I'm actually the one bringing it up because, you know, especially with clients, it's part of the intake. I asked them about their sexual satisfaction, and I even bring it up just like that. You know, "how satisfied are you guys with your sexual lives?" And for some of them, they look at me like I just said something totally random and weird. And I go, "well, this is part of it. Part of your relationship is sex."

A part of the normalization process is often reassuring clients that sexual health discussion were okay within the counseling relationship. Hannah stated:

> Sometimes they're uncomfortable and I just say, "you know, I'm sure that anything you have to say is nothing that I haven't heard before and just discuss whatever you're comfortable discussing," and I try to make it very comfortable for them.

When counselors reflected on their personal attitudes towards sex, they often reiterated sexual health as being a part of the total human experience. Zayn stated, "sexuality is something to be discussed and talked about and shared and not something to be ashamed of or hidden kind of like we have in society nowadays. There's a lot of shame around it." Similarly, Taylor stated, "I'm very open to it and I experience it as a positive thing, and I encourage people to enjoy it as a positive thing as well."

Openness. In addition to normalizing sexual health discussions, counselors demonstrated an attitude of openness to discussing and welcoming sexual health conversations. Solo used an open approach with his clients by stating:

> I'm open to whatever, let's put it that way. So, I felt like I would always come into a situation where sex was an issue in the kind of nonjudgmental way. You know, "you tell me what the issue is. We're not going to judge whether it's good or bad or, you know, ethical or any of that stuff". I'm pretty open when if something related to sex comes up, I'm pretty comfortable with gearing it in a way that's going to fit for their comfort level. Otherwise, we're not going to be able to talk about it.

Other counselors demonstrated openness by discussing sexual health concerns as they were brought up by the client. When discussing openness, Hannah reported, "I generally just followed their lead. I'm very open in discussing anything about their sexuality, but sometimes they're not, um, you know, I've had clients actually say to me, "I don't want to." In addition to being open to having sexual health discussions, counselors also reported an open mindset when addressing sexual health issues. Angela described her open approach as being nonjudgmental by stating:

> Being able to have a very open mind with sex, being able to speak openly without judgment towards people when they maybe come in and say, "this is something that I enjoy", um, provided that everybody involved is comfortable with what's going on, everybody is being safe, and everybody is on board with it. And just trying to keep a very open mind about the different ways in which people express themselves sexually, because it's very different person to person.

Counselors exercised openness to address sexual health topics that may have been relevant to the care being provided. Fredrick stated:

> One thing that I realized is that as a counselor, you have to be more willing to broach the subject with your clients. Otherwise, they may never bring it up and that can be a very, um, big, it can have a very, very big impact on who they are, especially when you're doing marriage counseling.

Dorian expressed excitement when she got the opportunity to openly discuss sexual health topics with her clients:

> I get kind of get hyped about it and I'm like, “Ooh, this will be great. This is going to be fun for us.” So that it's still like when you improve your sexual health and your sexual wellbeing, like a lot of joy, you know, I think it's just a really important area of most people's lives that they neglect. And so it's like super cool to see that part of them grow and change and how they can experience new pleasures and stuff like that. So I like it. I get really excited when they mentioned something and then two, it would also make me feel good, like as a therapist that they now feel comfortable with me, if we hadn't really talked about it where they told me, “(N)o, that's not really an issue”. And now they brought it up and they said, “well, this is the problem I have.” I think it's nice to know, like, all right, I'm making them feel comfortable and safe to discuss these things with me.

Lastly, all the participants expressed openness in their interviews by stressing the importance of this quality on effectively providing care. Angela summarized this sentiment when she said:

> It can have such a profound impact on, in general somebody's mental health, if they are not sexually fulfilled and especially in a relationship, it can cause so many issues within the relationship. There can grow to be resentment for things.

> Um, if, if there is kind of that difference in satisfaction, difference in desire, it can, um, breed some self-esteem issues. It, it can, it can really grow into this from, you know, just sex to a humongous issue in a relationship. And, and so I, I think that it has an incredibly profound impact on, on the work that we do and, and being able to talk about it and integrate sexual health into what we do is, I mean, it's inviting.

Dismantle Negative Messages about Sex. Counselors endorsed sex positive attitudes by dismantling negative messages about sex. For some participants, this started internally. For example, Patrick stated:

> I think that in general, we still live in a patriarchal society and working to dismantle that just one person, one therapist at a time I think is helpful. Um, so even just doing that self-evaluation, now that we're about, "okay, what are my beliefs around sex? What are the messages that I've inherited? What do I want to change about how I view sex as an individual and how can I help my clients on that journey as well?" So I think it starts with the self. So, I think it's a, it's a societal shift, but I think it's coming, but certainly needs to happen.

The internal process of dismantling negative messages was often the result of conflicting messages. Samantha stated:

> When I was younger, if you had casual sex, you hated yourself and you didn't know what love was and you know, all these different things. And so I think no matter how much we attempt to eradicate those biases from ourselves, indoctrination is still indoctrination. And so I think there's still a bigger part of me

> that would wrestle with those thoughts- that indoctrination that didn't necessarily match. They weren't congruent to what I thought.

Scilia's experience mirrored Samantha's when she provided an example of the impact that negative messages about sex had:

> Like the show Bridgerton that's on Netflix, you know, the daughter asking her mother, "what is the marital act?" And they don't even call it sex. They call it the marital act and the mom doesn't even know how to explain it herself. That's probably like one of the best representations of how sex is not talked about at home. And so people are confused and that's not to say all my, not all my clients are like that, but they kind of have that, just that contradiction, like growing up, "Oh, it's bad. You don't do it. You don't talk about it. You don't even think about it, but then once you're married, once you're married, then it's automatically, okay, you can do whatever you want" and it's confusing.

In addition to counselors dismantling negative messages about sex themselves, they also actively worked to dismantle negative messages to empower their clients. Patrick stated:

> So really empowering women to more fully embrace their own sexuality as much as they would like to. Um, obviously you don't want to push someone to do something that they don't want, their husbands are doing plenty of that. Um, but I think that's the biggest challenge is just that female empowerment within that sexual space is still very limited. Um, women and, you know, girls are not getting the messages that they, I believe they need to hear, um, in order to, um, to really own that.

Sexual Identity Development

Religious Influence. The journey to becoming more comfortable addressing sex personally and professionally was expressed by all 11 participants. The subtheme of religious influence was endorsed by eight participants. These participants discussed the contribution of religion influence on the development of their sexual identity. For Taylor, gathering additional information beyond his initial understanding of sex led to a shift in perspective:

> I'd say to start with growing up, because in the church, they told us, uh, you can only have sex if you're married. And we had to do the whole promise ring. Like we, we as teenagers, made a promise never to have sex until marriage. So it was very negative at that point in that timeframe and kind of gave a negative light to anything, even though they said during marriage, they didn't ever explained or express the positive of it in marriage. They just expressed the negative of it. And then through my professional development of pastoral training and then psychology training, I opened up more positively, um, to that, and then having my master's degree, that opened me up more because we had to encounter and engage with different clients that had different backgrounds. And then, uh, I guess, my personal experience came next because I opened myself up to explore my values and not wait until I was married at that point. And just, uh, you know, doing something different, living something different.

Similar to Taylor, Fredrick shared his experience of overcoming a negative religious influence:

> I grew up Catholic, there was a lot of shame and guilt around sex, um, unless it was in the framework of marriage. Um, and so like any sort of sexual desires needed to be repressed and things like that. And so, like the more I came to understand that that is a very dysfunctional way of thinking about sex and the more open I came, like the more open I came up about my sexuality and things like that, the more, um, I have moved higher up on the scale.

Zayn recalled his own personal shift, stating:

> Growing up, I was, you know, raised in a Baptist church. So, you know, that was very rule following and whatnot. And, um, over time, like I say, "experience is the currency of life". So, the more I've experienced, the more I've learned, the more I learn more people and heard their stories. It has given me that sense of compassion.

Negative religious influences were not the primary source of sexual identify development. Some participants reported a negative religious influence in regards to sex; however, Angela experienced a positive religious influence:

> I went to a church camp when I was younger, that was about God and sex. And that was really educational because they didn't say abstinence only, they said abstinence is, is, you know, kind of the preferred thing to do, but if you are not going to be abstinent because you're a teenager and your hormones are doing things to you, these are the ways that you can be safe. These are the things that, um, ways that you can express yourself, you know, safely with somebody and, um, and you know, talked about consent and, and all kinds of things.

Perspective Change through Exposure. As the participants were exposed to more sexual health related experiences, all 11 participants reported a shift in their perspectives. Angela discussed how her personal experiences with others led to her experiencing sex in a different way:

> As I have gone on in life and had had more friends that don't specifically define themselves in the heteronormative world. They may be heterosexual couples, homosexual couples, uh, pansexual couples, there are other ways to have sex. There are other ways to express yourself that are outside of just penis and vagina. And that was something certainly when I was younger, that I was taught that that was kind of like, that's what sex is, period. And as I have grown older, you know, opening up to different cultures of people and different, just different, different people, you know, everybody has different things that they like and dislike. And, and so, so I, I certainly would say because of that and because of the people that I surround myself with, I have opened my mind more to other definitions of sex and, and become much more comfortable in talking about and exploring those with people.

Ella shared how exposure to others led her to challenge her beliefs about sexuality and relationships:

> The more I was exposed to people who were in other sorts of relationships, it became very obvious to me that that was also love. And, there's this, when you're raised Christian and you're taught to believe that the Bible is literal and word for word, like there's a, a passage in the Bible that talks about, let us love one another for love is of God and anyone who is this born of God. And so the idea is like,

> love doesn't come from anywhere other than from God. And so, that was kind of like a, it was like a cognitive challenge for me.

For Fredrick, perspective change came through exposure to conversations relating to sex or sexuality with his friends:

> Just talking about sex with friends. Um, like I said, because it's so taboo within the culture, I think once I realized that there were some people I could talk to about sex and, um, have it not be taboo, it just seemed to be like a natural conversation, natural thing that everyone, or at least most people desire. Um, then it made it less about like myself and about this thing that I need to repress and keep hidden from everybody and more of like, okay, everybody has these desires. They're more, um, common, they're more, uh, universal than I thought that they were

Given that sexual health is a broad topic, Samantha discussed continued perspective changes: “I think once I'm exposed to something, if it hits a discomfort in me, then that's where I need to go get more education supervision, or what have you. I've wished I've done like specific sex focus training.” Dorian reported that her perspective shifted when she was exposed to different sexual relationships in the media and through her friends:

> Uh, don't make fun of me, but a TV show changed me and changed the game and books. I used to read a lot of books and like a young adult, like a fiction and stuff like that. So like falling in love with different characters and things like that to where you're like emotionally invested. I mean, that actually, like, I'm really sad or no, they can't be together. Or, you know, whatever. Like actually like

> experiencing them [the characters] from a human kind of way is what probably changed it for me. Like I had to like see people that I cared about, like characters and shows and then think, “these are real things, and there's nothing wrong with these things”. And then as television too also became less censored like Netflix and stuff. We could actually see things, you know, that my parents would call rated R. It's not gross. Like people do this. And there's like, lots of people that do this enough to where they felt like this made sense to put on the TV show that's nationally televised or whatever. I think being able to see things more openly helped me in my mind. Um, but also again, growing up, going to college, uh, stuff like that, you experienced more things. And so I also had friends that were different from me. Uh, once I got into, once I left high school, having friends that are different from you will change your perspective.

Counselors’ Role

Each of the 11 participants endorsed several aspects of a counselor’s role as a contributor to addressing sexual health successfully. Counselors reported that integrating sexual health into their practice was a part of their role as a counselor. Samantha stated:

> It’s my job in the counseling room. It's my job to have the uncomfortable conversation. Because the client likely has been avoiding or not around people willing in their own personal lives to have these uncomfortable conversations. And so even if we got off the subject of sex, we could be talking about anything. Ultimately, I have the duty in the counseling room to broach anything that's uncomfortable and to show and to model for that client, the ability to have uncomfortable conversations.

Fredrick discussed his ethical responsibility as a counselor when stating, “if it would have made me uncomfortable, I would have tried to either refer out saying I'm not ready for this or something, which would have been unethical of course. But, now that, uh, I've kind of done my own work, I feel as though I've increased my awareness.” Solo reported that as a counselor, he met his clients where they were at when addressing sexual issues: “I will say to them, tell me if there's anything that we're talking about that you're uncomfortable with so that I know how I can talk. I can be very graphic in the words that I use or I could be very clinical. It depends. it's going to depend on what they're most comfortable with.”

Providing a safe space for clients to discuss sexual concerns was reported by several counselors as a part of their role. For example, Hannah stated:

> I think just providing a safe space to be able to talk about it, um, for them. And then when working with couples, I think it's important to provide a safe space for them to be able to talk about it together. Um, you know, and sometimes some couples will start a conversation and then they want to add personal details later in private, which is fine. Um, and sometimes they're comfortable discussing with me there.

Zayn discussed his role as a counselor specifically:

> My role is to help the client give voice to their maybe unvoiced feelings or unvoiced thoughts that were considered too naughty, too bad, too impure and really give them the room and the space to talk about those things. Maybe any sexual traumas as well, that they've experienced in a nonjudgmental way to really give them permission, to feel and to be who they are.

While counselors discussed parts of their role such as ethical care, meeting the client where they are at, and providing a safe space, Dorian expressed that addressing sexual health was also a part of the counselor's role:

> It's definitely a disappointment. I appreciate people trying to give me referrals, but it's awful. Like I'm not EMDR certified, but we're all trauma informed. Like you're not going to say no to helping someone resolve their trauma just because you don't have an EMDR certification. Why would you send somebody to me for sex?

Synthesis of the Experience

The research question that was addressed for this study was: What are the experiences of counselors who have successfully integrated sexual health into their work with clients? Through the data collection process, I sought to find the essence of how professional counselors integrated sexual health into their practice successfully (see Figure 1), including their attitudes towards sexual health, their identity development, and their role as a counselor.

The essence of the participants experiences in this study indicated that a culmination of factors led to successful integration of sexual health. Counselors simultaneously developed sexual identities while dismantling negative messages about sex to endorse a sex positive attitude. For each participant, no single layer or theme was present without the other and each factor contributed to the counselor's ability to successfully address sexual health topics. The participants were influenced by knowledge, experience, and their commitment to the profession, which combined, increased their willingness and openness to integrate sexual health into their work.

Successful integration of sexual health was the outcome for counselors who simultaneously engaged in multiple processes. Each factor was influenced by the other factors. Counselors discussed their understanding of sexual health, which influenced their attitudes and behaviors as professional counselors. Counselors also demonstrated their critical evaluation of negative messages and the process of creating new scripts, which were congruent with their professional role and personal attitudes. This is a critical element of social constructivism. Counselors also iterated integral aspects of their professional role, which increased motivation to provide competent and compassionate care.

The textural-descriptions of the participants in this study captured the uniqueness of the participants' experiences while also capturing the significant overlap within the population. They also captured the essence of the lived experiences of professional counselors who successfully integrate sexual health into their clinical practice. While each participant shared a different journey, personal experience, and professional experience, they shared a commonality: each participant was able to successfully integrate sexual health into their practice because they have engaged in multiple processes of growth and development.

Taylor demonstrated the overlap of contributing factors (education and attitude) when he stated:

> I remember from school, they basically encouraged us to be open-minded with different clients and whatever they experienced with their sexuality, or either with their relationships and that whatever kind of a relationship they're in, they'd help us challenge our beliefs about that if we had any.

Counselors had positive attitudes about sex and highlighted the need for education and self-evaluation. For example, Samantha stated:

> I have no problem stacking my caseload because they were looking for someone who had the willingness, because I will say, I do think counselors are good-hearted. I don't mean it to sound that way. I think that they are scared of what they don’t know. And so that means some additional training.

Incorporating competency, having a sex positive attitude, doing their own personal work, and fully stepping into the role of a counselor were all combined to create an experience of a counselor who successfully integrated sexual health. Patrick discussed how each of these components overlap to influence the experience as a whole:

> I would just say that sex is important, sexual health is important. It's a part of who we are. It's a part of our expression. It's a part of how we represent ourselves to the world. And it's something that unfortunately is ignored or in some cases even shamed for it. Um, and I think that that's just simply a disservice to, to any human being, to have their sexuality quashed in that manner.

The experience of these 11 participants was that professional counselors used a multitude of methods and processes to inform their lived experience of integrating sexual health. There were many factors that influenced their success, which combined created a unique developmental experience.

Summary

In this chapter, I presented the four themes and corresponding subthemes that emerged from the transcriptions of 11 professional counselors. I presented descriptors to support each of the themes and provided a synthesis of the essence of the participants

experience (Moustakas, 1994). In Chapter V, I provide a summary of the study and a discussion about the findings. I also discuss the implications and recommendations for professional counselors and counseling students to elevate their practice and incorporate sexual health effectively. Specific interventions and approaches for training, counselor education, and supervision are discussed as well. Finally, I discuss the final conclusions for the study.

CHAPTER V

Discussion

The purpose of this study was to explore the lived experiences of professional counselors who successfully integrated sexual health into their clinical practice. Through a transcendental phenomenological lens, I was able to capture layers of the participants' experience with the phenomenon and develop insight into the overall essence of the experience. This final chapter of this dissertation contains a summary of the study, an analysis of the theoretical framework as it applies to the phenomenon, a discussion of the findings from the research, implications for future research studies, recommendations for counselor education, supervision and training and, finally, the conclusion of this study.

Summary of the Study

A transcendental phenomenological study was designed to understand the experiences of counselors who reported successfully integrating sexual health into their clinical practice. This study was designed to provide strategies to reduce counselor discomfort when integrating issues of sexual health into clinical practice. The recruitment process included steps to ensure that appropriate participants were selected for the study. Potential participants completed prescreening questions to determine if they were a fit for the study. Those who met the criteria for the study were recruited to participate in a semi-structured interview through Zoom. A total of 11 participants were recruited and completed the interview.

To collect and analyze data accurately, I implemented several measures to bracket myself from the phenomenon being studied (sexual health). Given my close relationship to the phenomena, I journaled before, during, and after each interview. I noticed in my

first interview that I engaged in nonverbal affirmations such as nodding and smiling in agreement. This further reinforced my need to continue journaling throughout not only the data collection process, but also the analysis and interpretation processes. Through member checking and peer debriefing, I was able to further bracket myself from the data. The data was collected and organized based on the recommendations of Creswell & Poth (2018) and Moustakas (1993). The data was analyzed using Moustakas's (1994) modification of van Kaam's (1959, 1966) method of analysis.

Four main themes emerged through the data analysis process. Each of the subthemes was supported by anywhere from eight to eleven participants. The first was counselor sexual health self-efficacy which included the following subthemes: (a) level of comfort; (b) lack of preparation; and (c) knowledge seeking. The second main theme was sex positive attitude, which included subthemes of: (a) normalizing sexual health; (b) openness; and (c) dismantling negative messages about sex. The third main theme was counselor sexual identity development, which included subthemes of: (a) religious influence; and (b) change in perspective through exposure. The fourth and final main theme was perception of a counselor's role.

Social Constructivism

Social constructivism, which posits that individuals learn and integrate information from their environment to shape the way they experience the world (Vygotsky, 1978), was the theoretical framework used to examine the perceptions and experiences of professional counselors and sexual health integration. According to Vygotsky (1978), individuals not only absorb information or knowledge from their environment, but they also critically evaluate and integrate the information internally,

leading to the continuing development of individual perceptions and judgements. Therefore, it seems to follow logically that counselors' perceptions and experiences related to sexual health integration would be a byproduct of external and internal processes.

Looking at the data, I conclude this to be the case and that participants engaged in social construction regarding their development of sexual health. They reported learning information about sexual health and hearing messages about sexual health across their lives, which subsequently influenced their evolving viewpoints and behaviors by evaluating information they gathered from their environments to make appropriate judgements about how to incorporate sexual health into their practice. For example, Patrick reflected a social constructivist perspective in his interview:

> I would just say that sex is important, sexual health is important. It's a part of who we are. It's a part of our expression. It's a part of how we represent ourselves to the world. And it's something that unfortunately is ignored or in some cases even shamed for way. Um, and I think that that's just simply a disservice to, to any human being, to have their sexuality quashed in that manner. Um, you know, and I think we have a long way to go, but I can definitely see that we're, we're making strides.

Moreover, thought the lens of social constructivism, I understood why some counselors feel comfortable integrating sexual health into their practice while other counselors report experiencing the following barriers to sexual health integration: lack of understanding (Dermer & Bachenberg, 2015; Graham & Smith, 1984; Haag, 2008; Lewis & Bor, 1994; Weerakoon, Sitharthan, & Skowronsk, 2008), low self-efficacy (Dermer &

Bachenberg, 2015; Miller & Byers, 2008; Russell, 2012), and negative attitudes (Anderson, 2002; Buehler, 2017; Dermer & Bachenberg, 2015; Dupsoki, 2012; Harris & Hays, 2008; Russell, 2012). The information gathered from their environment, combined with the meaning they attached to this information, appeared to influence participants' likelihood of integrating sexual health into their work, an experience that can be further explained through *sexual script theory* (Gagnon & Simon, 1973).

Sexual Script Theory. This theory is a branch of social constructivism which directly relates to the way individuals learn and develop schemas related to sexual health. According to Gagnon and Simon (1973), human sexuality is understood across three levels: cultural, social, and interpersonal. Through Sexual Script Theory (SST), Gagnon and Simon assert that an individual's subjective understanding of sex and sexual health determines an individuals' choices and behaviors with regards to sex.

From a clinical standpoint, participants used their own "sexual scripts" developed through knowledge and experience to guide the work they did with clients. One of the participants, Angela, reflected SST when she reported how learning and integrating new information created a shift in her personal sexual script, which then influenced the way she approached sex with her clients:

> I think just educating, educating people on the spectrum of sex that's out there, the different kinds of sex that people can have, making sure that people are educated on that and are, are kind of educated on, on best practices, as far as being able to talk to people about these different things. And, and for me, it opened my mind when I, you know, learned about new things sexually. It opened my mind into this different place where I do feel very comfortable talking about it. And I think that

> there are probably a lot of people who, who kind of still maybe think of that whole, you know, heteronormative penis in vagina. And that's what it is. And, and maybe even think that if their couple is going to talk about sex, that's what they're going to do. And then they're going to have somebody come in, who, who talks about their anal sex life. And if somebody doesn't feel prepared for it, then it, that can be negative.

Discussion of the Findings

The participants reinforced the counselor's responsibility to not only initiate conversations about sexual health, but to promote safe spaces for conversations related to sex. This may seem obvious given the role of a counselor; however, it was worth noting that in the view of each participant, counselors not practicing with client sexual health in mind are not practicing within the full scope of their role. Some participants specifically indicated that it was a counselor's ethical responsibility to address their own biases and to and manage their own discomfort as the alternative may impede client progress, which is reflected in the current ACA Code of Ethics. The ACA Code of Ethics (2014) establishes the counselor's ethical responsibility to exercise multicultural competence and practice in a nondiscriminatory manner based on personal biases. And while the ACA Code of Ethics (2014) encourages clients to practice within the scope of their professional competence, it also requires counselors to be culturally competent while being open to new information to best serve their clients. Given that sexual health overlaps with many multicultural layers (e.g. sex, age, sexual orientation, gender), it follows that counselors have a responsibility to integrate sexual health into their repertoire as part of culturally competent practice.

Other researchers pointed out that clinicians believed that if a particular subject challenged their self-efficacy, they were less likely to assess for, address, or intervene when those issues arise in session (Dermer & Bachenberg, 2015; Miller & Byers, 2008). Counselors who are not talking about sex may be reluctant to learn more about sex in general, perpetuating the problem of discomfort. They may avoid seeking sexual health education and training, leading to continued lack of self-efficacy, which further reinforces their reluctance to addressing sexual health issues. Interestingly, despite the participants' lack of professional training and education, they all demonstrated a proactive approach to seeking more knowledge about sexual health so that they could address the topic with clients, which is counter to previous research.

Participants not only demonstrated openness when discussing sexual health in the interview, they also reported exercising an attitude of openness when working with their clients to promote a comfortable and safe space for therapeutic work, which encompasses what is commonly defined as a *sex positive attitude* ("sex positive," 2021). Participants reported having normalizing conversations about sexual health, often reassuring their clients that sexual health discussions were safe within the therapeutic relationship and that sexual health issues could be addressed in counseling. They also reported providing education to clients to dismantle negative messages that had been internalized about sexual health. Most of the participants indicated that their attitude towards sex has shifted positively over the course of their life and professional career. Oftentimes, this was promoted by their personal efforts to learn more and improve their practice. Based on participants' collective reports, and consistent with the research (Russell, 2012), a sex

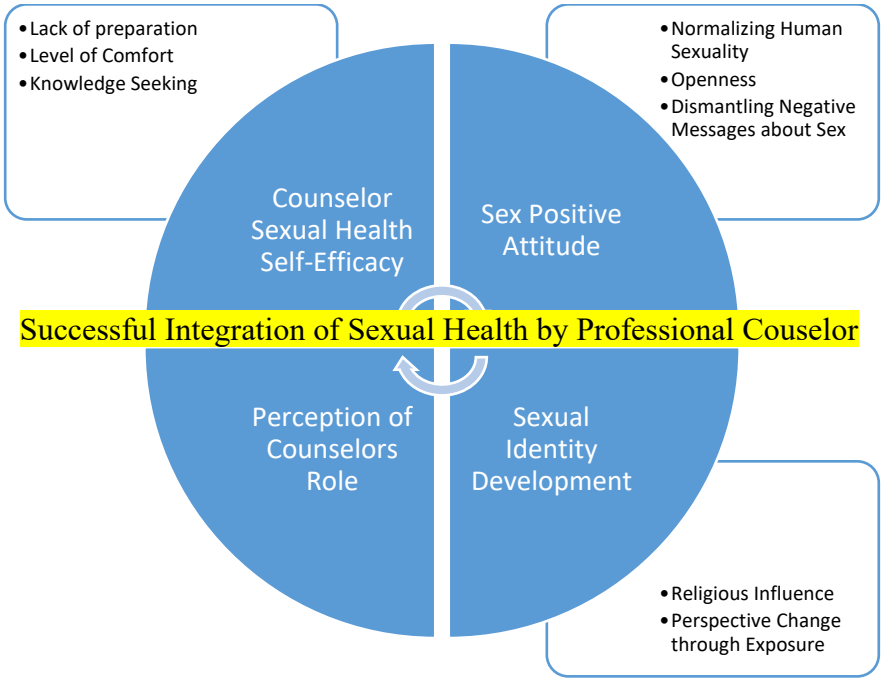
positive attitude improved participants' ability to navigate client sexual issues and improve treatment planning with clients.

Each of the counselors discussed how the various themes collectively contributed to their perspectives and behaviors. While previous research has focused on a single barrier at a time, counselors who integrated sexual health into their practice appear to have overcome such barriers; counselors sought out knowledge, demonstrated changes in their attitudes, and grew through their experiences. An assumption can be made that successful integration is not the result of addressing a single barrier, but rather a process targeting multiple layers of the whole counselor.

An interaction occurs across all of the themes, suggesting that successful integration is possible when strides are made in each of the themes collectively as opposed to a single area. For example, counselors who only seek out knowledge may have more information, but this does not necessarily lead to a shift in attitude or perspectives from experience. Figure 2 demonstrates how several factors related to the phenomenon might collaboratively work together to influence the whole counselor.

Figure 2

Synthesized Lived Experiences of Professional Counselors with Sexual Health



Note. This figure illustrates themes from this study that captured the experiences of professional counselors who have successfully integrated sexual health into their clinical practice.

Implications for Counselor Educators and Supervisors

A significant portion of the study's results points to limitations of counselor training programs. Counselors reported an overall lack of knowledge and exposure to sexual health in their training. Counselors also reported receiving no formal training on how to address sexual health issues when they came up. Counselor educators, supervisors, and training programs could benefit from enhancing training programs by equipping students with knowledge, skills, and experience to incorporate sexual health

into their work with clients. Given that counselors are likely to work with individuals and couples with sexual issues, improving counselor self-efficacy is necessary (Hipp & Carlson, 2019; Almas & Almas, 2016).

Counselors also have an ethical responsibility to provide comprehensive care to clients (Buehler, 2017). This begins with counselor training. Given that the study highlighted the interrelated nature of the themes, counselor education programs could require self-evaluation to assess the approaches educators are using to target each of these elements. For example, programs may evaluate if sexual health information is being taught in the classroom, including skills on how to address sexual health when it comes up in session. Programs could also evaluate how they are empowering students to assess their own biases about various topics, including sexual health.

Programs could also integrate experiential opportunities to interact with sexual health topics. While some researchers have proposed sexual health competencies (Zeglin, Van Dam, & Hergenrather, 2018), others have proposed infusion of sexual health across counselor training programs (Sanabria & Murray, 2018; Willard, 2019). This would provide students with experiences for increasing knowledge, practicing skills, engaging in open discussion related to sexual health, and personal attitudes assessments related to sexual health. Infusing sexual health across counseling programs provides exposure to sexual health related topics for students as well. This may be as simple as a sexual health related ethical dilemma or sexual health related counseling session role-play. Based on the results of the study, sexual health integration was influenced by commitment to the counseling profession and counselor role, knowledge, personal attitudes, and experience. Therefore, it is not enough for a counselor training program to simply provide

knowledge. Counselor training programs and supervisors must provide experiences which target students' knowledge, personal attitudes, skills, and overall exposure to sexual health.

Finally, counselor educators and supervisors could benefit from assessing their own values, biases, and attitudes related to sexual health as their beliefs color the experience they create for a student in the classroom. Recommendations for integrating sex positivity and discussion into counseling include exploring one's personal attitudes and beliefs, developing sex positive knowledge and comfort, understanding and integrating sex-positive multiculturalism and social justice work, proactively addressing sexual health topics, and knowing limits to sexual health discussions (Cruz, Greenwald, & Sandil, 2017).

Limitations

A major limitation of the study was that it was completed under the assumption that the participants' had in fact successfully integrated sexual health into clinical practice. Given that counselors self-reported successful integration, how each participant defines successful integration is unclear. To decrease the range of interpretation, I defined successful integration as a counselor who is a) willing to initiate discussions about sex or sex related topics; b) feels comfortable discussing sex or sex related topics; and c) willing to explore and address sex related topics. I also asked each participant what successful sexual health integration means to them during the interview. While there was some overlap between each participant, differences across responses still demonstrated diversity of interpretation. This was helpful in gathering information about successful

sexual health integration in general, but poses an issue for clearly defining sexual health integration for training and clinical purposes.

Lack of prior research on the topic was another limitation of the study. While a significant number of studies have been completed on barriers to successful integration, only a single study (Sangra, 2016) has explored successful integration. Because of this, there is limited information about what successful integration entails and the overall practice of successful integration. This study can be considered a preliminary study because it adds to the limited foundation of sexual health literature that is focused on successful integration.

According to Peoples (2020), using a diverse range of sources for data can deepen and broaden the understanding of the phenomena. The present study was limited to data collection from a demographic questionnaire and a semi-structured interview. Because there is little information about the topic of research, using additional sources for data collection may have been helpful in further understanding the phenomena. Future researchers may consider adding additional sources for data collection to elaborate on each of the identified themes.

The study was open to a national sample of professional counselors; however, all but one participant was geographically located in Texas. Thus, similarities across the data which contributed to the development of themes may not transfer to professional counselors who completed their training in other parts of the nation. Future researchers may consider diversifying their recruitment efforts and explore possible differences across geographical locations.

Other limitations of the study include results that reflect the experiences of individuals who only speak English, utilize social media platforms, and had been in practice as a fully licensed clinician for at least a year. Capturing the experiences of diverse counselors, counselors who may not have a social media presence, and counselors in training may have yielded different results.

Recommendations for Future Research

This study provided insight into the intricate and multifaceted nature of sexual health integration among professional counselors. It built on Sangra's (2016) approach of giving a voice to counselors who successfully integrated sexual health to explore potential best practices, which serves to diversify the sexual health literature that has been historically focused solely on barriers to addressing sexual health. In other words, this study promotes a shift from "what is not working" to "what is working." Future research can extend beyond this study by furthering the discussion about best practices for addressing sexual health in clinical practice. Given that participants indicated a lack of knowledge and training, research on the experiences of students and sexual health training could provide insight into training opportunities within counselor education programs so that students are better equipped with sexual health related knowledge and skills.

This study also highlighted the interconnectivity of multiple elements contributing to sexual health integration. Professional counselors indicated that they developed sexually through their personal and professional experiences. A grounded theory study on the sexual identity development journey might provide helpful insight on specific practices and experiences that led to a shift in attitudes related to sex. A grounded theory

study could also provide insight into the most influential experiences, which can then be integrated in counselor training programs.

Finally, a study on the experiences of counselor educators addressing sexual health in the classroom may provide additional data regarding the gap in education and training. If counselor educators experience the same reluctance towards sexual health as half of the clinician population (Buehler, 2017), then this will impact the knowledge discussions, and perspectives being shared in the classroom. Alternatively, it is possible that sex positive counselor educators cultivate learning opportunities, which targets the students' knowledge base and personal attitudes.

Conclusion

This transcendental phenomenological study explored the lived experiences of professional counselors with successful integration of sexual health. The results of this study suggest that multiple factors contribute to the participants' ability and willingness to integrate sexual health into their clinical practice. Participants engaged in a multitude of processes to arrive at a place of comfort and competence when addressing sexual health. They also reflected on their personal and professional experience and how these experiences motivated and shaped them to address their own biases and critically evaluate their own understanding of sexual health.

The were several implications for counselors and the counseling profession as a whole. First, results reinforced the notion that that every mental health professional needs to know about sex in order to provide ethical and competent care (Buehler, 2017). Secondly, through the study, counselors who successfully integrate sexual health were given a voice, moving away from a focus on counselors who experience barriers to

addressing sexual health. Finally, this study highlighted the interconnectivity of multiple elements which contribute to sexual health integration.

Several recommendations were made for counseling education and training programs. Given that the themes addressed multiple factors related to the whole counselor, counselor educators and programs could benefit from evaluating their current perspectives related to sexual health. They may also benefit from infusing sexual health across the curriculum in different ways such as discussions, attitude assessments, case scenarios, experiential activities, and knowledge.

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APPENDIX A

Sam Houston State University
Consent for Participation in Research

KEY INFORMATION FOR: *Counselors Experiences of Successfully Integrating Sexual Health into Clinical Practice*

You are being asked to be a participant in a research study about professional counselors experiencing integrating sexual health into clinical practice. This includes initiating discussions, feeling comfortable, exploring, and addressing sexual health issues with clients as they come up. You have been asked to participate in the research because you are a professional counselor who has reported successfully integrating sexual health and may be eligible to participate.

WHAT IS THE PURPOSE, PROCEDURES, AND DURATION OF THE STUDY?
The purpose of this study is to learn and understand the experiences of professional counselors with discussing sexual health with clients. Professional counselors who are able to comfortably initiate, explore, and address client sexual health issues may contribute helpful information to support other counselors and students. By doing this study, we hope to learn from experiences of professional counselors who already discuss sexual health with clients. Your participation in this research will last about one hour to two hours.

WHAT ARE REASONS YOU MIGHT CHOOSE TO VOLUNTEER FOR THIS STUDY?
By participating in this study, you will be contributing to the growing body of research on sexual health in clinical practice. While there may not be a direct benefit, this study may increase your insight on how integral your role can be in supporting the professional development of other counselors and providing comprehensive client care. For a complete description of benefits, refer to the Detailed Consent.

WHAT ARE REASONS YOU MIGHT CHOOSE NOT TO VOLUNTEER FOR THIS STUDY?
Time limitation may be a factor to consider for this study. Your participation will require about one to two hour of interview time. For a complete description of risks, refer to the Detailed Consent.

DO YOU HAVE TO TAKE PART IN THE STUDY?
If you decide to take part in the study, it should be because you want to volunteer. You will not lose any services, benefits, or rights you would normally have if you choose not to volunteer.

WHAT IF YOU HAVE QUESTIONS, SUGGESTIONS OR CONCERNS?

The person in charge of this study is Sana Vawda, a doctoral student of the Sam Houston State University Department of Counselor Education and Training who is working under the doctoral supervision of. Dr. Jeffery Sullivan for her dissertation. If you have questions, suggestions, or concerns regarding this study or you want to withdraw from the study his/her contact information is: sxv041@shsu.edu and jms107@shsu.edu, respectively. If you have any questions, suggestions or concerns about your rights as a volunteer in this research, contact the Office of Research and Sponsored Programs – Sharla Miles at 936-294-4875 or e-mail ORSP at sharla_miles@shsu.edu.

Sam Houston State University

Consent for Participation in Research

DETAILED CONSENT*: Counselors Experiences of Successfully Integrating Sexual Health into Clinical Practice*

Informed Consent

My name is Sana Vawda and I am doctoral student in the Department of Counselor Education & Supervision at Sam Houston State University. I would like to take this opportunity to invite you to participate in a research study of professional counselor's experiences with integrating sexual health discussions into their clinical practice. I am completing this study for my doctoral dissertation under the direction and guidance of my dissertation chair, Dr. Jeffery Sullivan in the Department of Counselor Education & Supervision. I/We hope that data from this research will introduce the voices of professional counselors who integrate sexual health into research and discussions about sexual health in the clinical community. You have been asked to participate in the research because you are a professional counselor of at least 1 year who discusses sexual health with his/her clients comfortably.

The research is relatively straightforward, and we do not expect the research to pose any risk to any of the volunteer participants. If you consent to participate in this research, you will be asked to complete an interview with me which will last about one to two hour. During this time, I will ask questions about your experience integrating sexual health into your clinical practice and, if you'd like, check in with you to make sure I am collecting information that is an accurate report of your experience (member checking).

Any data obtained from you will only be used for the purpose of understanding the experiences of professional counselors to ultimately improve counselor education and training. Under no circumstances will you or any other participants who participated in this research be identified. In addition, your data will remain confidential.

This research will require about one to two hours of your time. Participants will not be paid or otherwise compensated for their participation in this project. Participant interviews will be audio/video recorded to be transcribed. This is available for you to review (recording and/or transcription) and will be destroyed three years after the project's completion. Until then, it will be stored on a password protected, encrypted flash drive and will be stored in a secure location.

Your participation in this research is voluntary. Your decision whether or not to participate will involve no penalty or loss of benefits to which the subject is otherwise entitled, and the subject may discontinue participation at any time without penalty or loss of benefits to which the subject is otherwise entitled. If you have any questions, please feel free to ask me using the contact information below. If you are interested, the results of this study will be available at the conclusion of the project.

If you have any questions about this research, please feel free to contact me, Sana Vawda, or my dissertation committee chair, Dr. Jeffery Sullivan. If you have questions or concerns about your rights as research participants, please contact Sharla Miles, Office of Research and Sponsored Programs, using her contact information below.

Sana Vawda SHSU Department of Counselor Education & Training Sam Houston State University Huntsville, TX 77341 Phone: (979)-429-3829 E-mail: sxv041@shsu.edu	Dr. Jeffery Sullivan Dissertation Chair SHSU Department of Counselor Education & Training Sam Houston State University Huntsville, TX 77341 Phone: (936) 294-4657 E-mail: jms107@shsu.edu	Sharla Miles Office of Research and Sponsored Programs Sam Houston State University Huntsville, TX 77341 Phone: (936) 294-4875 Email: irb@shsu.edu

☐ I understand the above and consent to participate.

☐ I do not wish to participate in the current study.

AUDIO/VIDEO RECORDING RELEASE CONSENT

As part of this project, an audio/video recording will be made of you during your participation in this research project for transcription purposes only. This is completely voluntary. In any use of the audio/video recording, your name will not be identified. You may request to review the recording. Additionally, the recording will be destroyed after three years of the project's completion, along with the transcription of your recording. You may request to stop the recording at any time or to erase any portion of your recording.

☐ I consent to participate in the audio/video recording activities.

☐ I do not wish to participate in the audio/video recording activities

APPENDIX B

Interview Questions

1. What education or training, if any, have you had regarding sex, sexual health, sexuality or even talking to your clients about sex (Cruz, Greenwald, & Sandil, 2017)?
2. What does successful integration of sexual health, sexual topics or sexuality into counseling mean to you?
3. Tell me about your experience with discussing sexual topics with your clients
4. What steps have you taken to improve your experience of discussing or addressing sexual concern with clients?
5. What factors do you believe have had the biggest impact on your ability to discuss sex or sex related topics with your clients?
6. Sex positive is defined as having or promoting an open, tolerant, or progressive attitude towards sex and sexuality. On a spectrum from sex negative to sex positive (1-10), where would you place yourself today? Has that position changed or shifted over time? If so, how has it changed? (Cruz, Greenwald, & Sandil, 2017)
7. What challenges, if any, have you or do you continue to face as you have conversations about sex with your clients?
8. Based on your experiences, what feedback or information do you believe is helpful for counselor training, education, and preparation?

APPENDIX C

Demographic Questions

Pseudonym:

Gender:

What is the title of your professional license?

What state are you licensed in?

How many years have you been fully licensed?

What are your specialty areas (if any)?

What is/are your current practice setting?

What setting(s) did you complete your training in?

Ethnicity:

APPENDIX D

Table 2

Assigned Names and Demographic Information for Participants in the Study

"Name"	*Gender*	*License*	*State*	*Years*	*Specialty*	*Practice Setting*	*Training Setting*
Samantha	Female	LPC	TX	1.5	Couples LGBT	Private practice	Private practice, Hospital
Solo	Male	LPC	NJ	15	Adolescents Families	Private practice	Hospitals, Schools
Scilia	Female	LPC	TX	2	Mothers Women Relationships	Private practice Agency	Private practice, Hospital
Taylor	Male	LPC-S	TX	13	Forensics Juvenile Justice	Outpatient Community Mental Health	Community Mental Health, nonprofit
Fredrick	Male	LPC	TX	1			Crisis center, Agency
Patrick	Male	LPC	TX	4.5	Couples	Private practice	Inpatient hospital, Crisis center
Angela	Female	LPC	TX	1.5	Couples	Private practice Hospital	Support groups, Private practice, IOP, Hospital
Hannah	Female	LPC	TX	26	Anxiety Couples	Private practice	Private practice
Zayn	Male	LPC	TX	1.5	Financial counseling	Private practice	Private practice, Community mental health
Dorian	Female	LPC	TX	2	Interpersonal relationships	Private practice	Private practice, group practice, jail, hospital
Emma	Female	LPC	TX	22	Families Welfare	Consulting Private practice	Campus mental health

VITA

Sana Vawda
Licensed Professional Counselor
Doctoral Candidate

EDUCATION

PhD Counselor Education	Sam Houston State University, current Graduation Date: July 2021
MA Counseling	Houston Baptist University, 2017
BSA Human Development & Family Sciences	University of Texas, 2015

LICENSES AND CERTIFICATIONS:

Licensed Professional Counselor - Texas State Board of Examiners of Professional Counselors
Licensed Chemical Dependency Counselor (Intern)
Certified Sex Therapy, candidate; Texas Sex Therapy Institute (TSTI)
Eye Movement Desensitization and Reprocessing (EMDR) trained
Ericksonian Hypnosis for Psychotherapy Mastery Course & Certification
Cognitive Behavioral Therapy Certification
Trauma-Focused Cognitive Behavior Therapy Certification
Texas Educator Certificate (Generalist EC-6)

CLINICAL EXPERIENCE:

New Horizon Hospital	Director of IOP/ Clinical Director	2020- present
Total Therapy Mental Health & Wellness	LPC (Owner)	2020- present
Abundant Life Therapeutic Services	LPC	2019- 2020
LPC-Intern		2017- 2019
Center for Research and Clinical Training in Trauma (Doctoral)	Graduate Assistant	2019- 2021
Insightful Life Counseling Center, LLC	LPC - Intern Practicum Student	2017-2018
Community Counseling Center- SHSU	Doctoral Supervisor	2019
Community Counseling Center- SHSU	Practicum Student	2018
Michelle Garcia PsyD & Associates	Practicum Student	2017-2018

PROFESSIONAL EXPERIENCE:

Sullivan, J., & **Vawda, S.** (February, 2020). Keeping it real: Teaching genuineness in the counseling relationship through education and supervision. Presented at Texas Association for Counselor Education & Supervision (TACES) conference, San Antonio, TX.

Vawda, S., Young, N., & Akay-Sullivan, S. (February, 2020). From preparation to practice: Improving clinical components in Counselor Education. Presented at Texas Association for Counselor Education & Supervision (TACES) conference, San Antonio,

TX.

Vawda, S., Webb, D., & Lawson, D. (February, 2020). Addressing the neglected trauma: Implications for counselor education and supervision for DID clients. Presented at Texas Association for Counselor Education & Supervision (TACES) conference, San Antonio, TX.

Lawson, D., Akay-Sullivan, S., & **Vawda, S.** (March, 2020). Suicide: Trauma informed treatment for children, adolescents and adults. Presented at The Center for Research & Clinical Training in Trauma (CRCTT) workshop, The Woodlands, TX.

Vawda, S. & McCarthy, L. L. (June, 2020). Sexual communication: It's time to talk. Presented at American Association of Sexuality Educators, Counselors and Teachers (AASECT) Conference, Palm Springs, CA. (cancelled)

GRADUATE TEACHING

Sam Houston State University

COUN 6374:Practicum Group Counseling*, Summer 2018*
COUN 5364:Theories in Counseling, *Summer 2019*
Person Centered Therapy
Gestalt Therapy
COUN 5385:Pre-Practicum: Techniques of Counseling, *Fall 2019*
Empty Chair Technique
Early Recollections Technique
COUN 5392: Cross Cultural Issues in Counseling, *Summer 2020*
COUN 6376: Supervised Practicum in Counseling, *Summer 2020*

UNDERGRADUATE TEACHING

University of St. Thomas

DAAC 1310: Individual and Group Skills, *Fall 2020*
DAAC 1310: Individual and Group Skills, *Spring 2021*

Sam Houston State University

COUN 3321:Introduction to Helping Relationships, *Fall 2018*
The Personal & Professional Boundary in Helping Relationships (Self-care)
COUN 3321:Introduction to Helping Relationships, *Summer 2019*
The Personal & Professional Boundary in Helping Relationships (Self-care)

OTHER TEACHING

Harmony School of Achievement, Harmony Public Schools

Grade 5 Science Teacher 2016-2017
Grade 4 Math & Science Teacher 2015-2016

PROFESSIONAL AFFILIATIONS

American Counseling Association (ACA)
Texas Counseling Association (TCA)

Association for Counselor Education and Supervision (ACES)
Texas Association for Counselor Education and Supervision (TACES)
Southern Association for Counselor Education and Supervision (SACES)
American Association of Sexuality Educators, Counselors and Teachers (AASECT)
American Psychological Association (APA)
Psi Chi Honor Association (2016-2017)

COMMUNITY SERVICE
Presented a training titled, "Nurturing in the Sunday School Classroom" for staff at Masjid Al-Mustafa (August, 2018)
Counselor of Bear Creek Weekend Islamic School (2017-2018)
Assistant Principal of Bear Creek Weekend Islamic School (2016-2018)
Presented a lecture titled, "Becoming Your Best You Before Saying I Do!" at Get HITCHED! Muslim Singles Conference (2018)
Presented a seminar titled, "Sunday School Classroom Behavior Management" for staff at Masjid As-Salam (October, 2017)

PROFESSIONAL DEVELOPMENT & TRAININGS
Association for Counselor Education & Supervision Conference; October 2019
Center for Play Therapy Fall Conference
CCPT 101: Basics in Child-Centered Play Therapy (12 CUEs); May 17-18, 2019
Transforming Every day into Play Therapy Interventions (3 CEUs); May 4, 2019
Seeking Safety – Treatment Innovations; September 2019
The Experiential Mindset in Therapy: An Introduction to Gendlin's Focusing Model
Prosecuting Domestic Violence: Understanding Trauma Victims and the Challenges Seeking Justice (3 CEUs)
Evolution of Psychotherapy; December 2017

SKILLS
Program Development
Online Course Development: Blackboard, Kaltura & Canvas
Proficient with Microsoft Office
Proficient with basic web development & mental health marketing