

Counselors' Perception of Sexuality in Counseling: A Pilot Study

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Abstract

In spite of a recent emphasis on the developmental nature of sexuality, the counseling profession does not promote a consistent definition of sexuality or guidelines for conducting sexuality counseling. Using a qualitative approach, this study was conducted to examine the construct “sexuality” and “sexuality counseling” from counselors’ perspectives. One synchronous online focus group and two online individual interviews were conducted with counselors predominantly in the Southeastern United States. Themes from the data include: sexuality is multi-dimensional; sexuality is developmental; sexuality counseling is dialectical; and sexuality training in counseling is insufficient. Implications of these findings for counselors, counselor education, training, and supervision are discussed.

Sexuality is a universal experience that encompasses and impacts every stage and aspect of our lives; yet, the mere mention of sex evokes a barrage of emotional responses, challenges our cultural and religious belief systems, and invites controversy. Given the power of sexual expression to speak so clearly about who we are, it is no surprise that the study of sexuality has been focused on in psychology (Lazarus, 2008). In spite of its significance, sexuality is often approached with caution or avoided altogether during the counseling process (Parritt & O’Callaghan, 2000; Southern & Cade, 2011). After a significant gap in the literature, a renewed interest in sexuality has begun (Dupkoski, 2012; Jackson, 2010; Southern & Cade, 2012), along with challenges to examine the impact of history and culture, as well as the professional atmosphere. Training related to sexuality is imperative to advance sexuality counseling (Bullough, 1975; Dupkoski, 2012; Fyfe 1980; Sachs & Duffy, 1976).

Historical and Cultural Influences on Sexuality

Through multi-disciplinary efforts and societal changes, Western society has made significant advances in our understanding of sexuality in a relatively short period of time (Beasley, 2008; Jackson, 2010; Lazarus, 2008). Historically, Western sexual values were largely founded upon Puritanism, which emphasizes sexual expression within the confines of a marital relationship for the purpose of procreation, defined in America as the union between one man and one woman (Beasley, 2008; Jackson, 2010; Lazarus, 2008). Through the efforts of sexuality research pioneers like Alfred Kinsey and Masters and Johnson, definitions of “normal” sexual expression in America moved away from adherence to a moral code to examining the actual expression of sexual behavior (Kinsey, 1953; Kinsey, 1948; Lazarus, 2008; Nasserzadeh, 2009; Sexuality Encyclopedia, 2012). The sexual revolution of the 1960’s challenged the necessity of

marriage to engage in sexual activity (Pastor, Mageland, & Findley, 2014). In the medical field, studies by Money examined the construct of gender and introduced means of preventing unwanted pregnancy (Lazarus, 2008; Money, 1988), and the AIDS epidemic shook our country and heightened awareness on sexual health issues. Currently, the Human Rights Campaign, along with many other organizations and individuals, are challenging the societal definition of marriage itself (Human Rights Campaign, 2014).

As social changes occurred, new theories were introduced to conceptualize sexuality from different perspectives. Beginning with Freud's psychosexual stages of development, developmental theories recognize that sexuality varies throughout the lifespan based upon age and stage of life (Freud, 1976; Lazarus, 2008; Southern & Cade, 2011). From a sociological perspective, sexuality is viewed as a social behavior with norms determined by social and cultural factors (Diamond & Hubener, 2012; Lazarus, 2008; Paiva, 2005; Southern & Cade, 2012; Trimble, 2009). For example, social learning theory asserts that sexual pleasure is a powerful reinforcer for sexual behavior learned through modeling (Hogben & Byrne, 1998; Petersen & Hyde, 2010; Sachs & Duffy, 1976).

Medical Perspective of Sexuality

In the past two decades, sexuality in America has become increasingly medicalized, particularly with the introduction of medications, such as Viagra, to address erectile dysfunction (Tiefer, 2010). Based on the sexual response cycle identified by Masters and Johnson in the 50's, medical approaches to "normalizing" sexual behavior involve diagnosing sexual dysfunction based on deviation from the stages of the sexual response cycle (Bullough, 1975; Southern & Cade, 2011) and prescribing treatments designed to resolve undesirable symptoms. Such treatments can often include medication (APA, 1952; APA, 1968; APA, 1980; APA, 1994; APA, 2000; Bradley & Fine, 2009; Sexuality Encyclopedia, 2012). This approach is based on the premise that sexuality is a health concern. Therefore, there is an emphasis on alleviating disease, dysfunction, and disorder to regain a sense of health and functioning (Bradley & Fine, 2009). Although sex therapy also focuses on various psychological interventions such as behavioral modification and relaxation techniques to address sexual dysfunctions, many individuals choose to pursue medical treatment to avoid stigma and resolve symptoms quickly (Bullough, 1975; Southern & Cade, 2011). As such, sex therapy as a profession has embraced the medical approach to intervention. As sex therapy became increasingly focused on using medicalized treatment approaches, counselors' discomfort in addressing sexuality with clients increased (Bradley & Fine, 2009; Hays, 2008; Southern & Cade, 2011; Tiefer, 2006). In turn, sexuality has been identified as a specialization in counseling (Nasserzadeh et al., 2009; Southern & Cade, 2011), in spite of affirmation of sexuality's developmental nature (Diamond & Huebner, 2012; Elders, 2010; Fyfe, 1980; Gill & Hough, 2007; Southern & Cade, 2011; Trimble, 2009).

Sexual stigmatization has led to increased advocacy for the recognition of sexual rights and an emphasis on a more holistic approach to sexuality counseling that includes addressing social, cultural, and political influences on sexual functioning (Tiefer, 2010). As women's sexuality is particularly emphasized in recent literature, some authors recommend that women be allowed to define their own sexual problems based on psycho-bio-social aspects of sexuality (Tiefer, 2010). As an alternative to the medical model, The Campaign for a New View of Women's Sexual Problems was introduced in 2000, which demonstrates a social constructionist

perspective on sexuality (Southern & Cade, 2011; Tiefer, 2006). It was created for two reasons: to serve as a watchdog for pharmaceutical companies and to educate the public and professionals about the limitations of the medical model (Teifer, 2006, 2010). The alternative lens of women's sexual problems views a sexual problem from a biopsychosocial perspective (Tiefer, 2006), with concerns presenting themselves in one of four areas: sociocultural/political/economic, partner/relationship, psychological, or medical factors. These four areas are then broken down into sub-areas for further elaboration.

Current Views of Sexuality in Counseling

Sexuality is increasingly being recognized as more complex than mere biological function across disciplines, and the counseling profession demonstrates an advanced appreciation of this complexity (Bogey, 2008; Fyfe, 1980; Gill & Hough, 2007; Jackson, 2010; Lazarus, 2008; World Health Organization, 2012). Rather than emphasizing sexual dysfunction and function based upon a sexual response cycle developed decades ago, sexuality is beginning to be viewed in terms of wellness. Wellness approaches show some consistency in perceiving sexuality as a holistic and developmental experience, embracing sexual expression as a key aspect of personality and emphasizing variation from the binary system of conceptualizing gender identity and roles (Roscoe, 2009; Southern & Cade, 2011; Trimble, 2009). In addition, wellness models view sexuality as essential to overall wellness (Beasley, 2008; Paiva, 2005), even if it is not highlighted as a core dimension in wellness models (Myers & Sweeney, 2005, 2008; Roscoe, 2009).

Although sexuality is being conceptualized overall from a more holistic perspective, the language used regarding sexuality in counseling is still based on a medical, rather than wellness, perspective. Sexuality counseling has been perceived as a specific type of counseling that is implemented only when the client enters treatment for a sexual "problem" (Southern & Cade, 2011). The New View of Women's Sexual "Problems" is based upon the same concept. It is often anticipated that the client will introduce a sexual problem rather than incorporating sexuality as part of an initial assessment, using language that implies a positive experience and inviting clients to talk about their experiences.

Furthermore, there has been an assumption that counselors need to "coexist with the medicalization of sex therapy for the benefit of our clients and our profession" (Bradley & Fine, 2009, p. 77). Part of distinguishing between the roles and functions of sex therapy and sexuality counseling includes specifying that sex therapy is designed to address sexual dysfunction and dissatisfaction (Southern & Cade, 2011). Even when counselors address sexual "problems," it is necessary to encourage medical screening before intervening and then to implement treatment from a holistic perspective (Southern & Cade, 2011).

Definition of Sexuality Counseling

In spite of efforts to clarify sexuality counseling within the Counseling profession, there remains a great deal of ambiguity regarding how sexuality and sexuality counseling are defined (Dupkoski, 2012; Jackson, 2010; Tiefer, 2006). The term "sexuality counseling" is used across multiple disciplines. The term is generally viewed as the promotion of sexual health (van der Kwaak, van Kats, & Dieleman, 2010) in the medical field and sexual satisfaction and optimal sexual functioning in the counseling field (Southern & Cade, 2011). Confusion and inconsistency

regarding the nature and scope of sexuality interventions (Bogey, 2008; Dupkoski, 2012; Fyfe, 1980; Jackson, 2010; Nasserzadeh, 2009; Southern & Cade, 2011; Parritt & O'Callaghan, 2000; Tiefer, 2006; Trimble, 2009; van der Kawaak, Ferris, van Kets, & Dieleman, 2010) can contribute to ineffectiveness when addressing sexuality with clients (Parritt & O'Callaghan, 2000). Encouragement to increase training regarding sexuality in Counselor Education programs has not led to significant changes in programming (Fyfe, 1980; Paiva, 2005; Trimble, 2009), and little has been published about how counselors conceptualize and incorporate sexuality and sexuality counseling into practice (Hays, 2008; Parritt & O'Callaghan, 2000). Because sexuality accounts for approximately 30% of health care costs in the United States (Elders, 2010), it is advantageous that counselors have some form of standardized educational and training foundation in sexuality counseling.

Training and Certification in Sexuality Counseling

Although some authors have proclaimed sexuality counseling to be a specialization for which extensive training is required (Gill & Hough, 2007; Nasserzadeh, 2009; Southern & Cade, 2011), others affirm that it is, in fact, an area in which all counselors should have some basic competency (Dupkoski, 2012; Fyfe, 1980; Mallicoat & Gibson, 2014). Unfortunately, training and certification is as inconsistent as how sexuality counseling is defined. With the premise that sexuality counseling is a specialization, graduate level training in Counseling is focused within the Marriage, Couples, and Family Counseling concentration (CACREP, 2009), and although post-graduate training and certification is available, these opportunities fall within the realm of sex therapy rather than sexuality counseling (AASECT, 2014; Dupkoski, 2012; Gill & Hough, 2007).

In Counselor Education programs, the Council for the Accreditation of Counseling and Related Educational Programs (CACREP) does not require sexuality counseling training for any concentration except Marriage, Couples, and Family Counseling (CACREP, 2009). Although some programs do offer an elective course in sexuality counseling, many programs do not, robbing counselors in training of opportunities to receive training prior to entering the profession (Dupkoski, 2012; Mallicoat & Gibson, 2014). Focusing training into Marriage, Couples, and Family Counseling programs may reinforce a perception that sexuality is only relevant within this context (Dupkoski, 2012) and that it is, indeed, a specialty because it is not the knowledge itself that impacts counselors but how counselors "experience knowledge related to sex" (Trimble, 2009, p. 59). In addition, lack of training for all counselors, regardless of concentration, may contribute to many counselors reporting feeling uncomfortable addressing sexual issues with clients (Jackson, 2010; Gill & Hough, 2007; Parritt & O'Callaghan, 2000; Southern & Cade, 2011).

Although the literature indicates that the nature of sexuality interventions has been consistently unclear with regards to who provides the interventions and what treatments require specialized training (Elders, 2010; Gill & Hough, 2007), post-graduate training and certification is available when counselors are willing and able to devote the additional money and time. The best known organization with professional standards for sexuality counseling is the American Association of Sex Educators, Counselors, and Therapists (AASECT) (AASECT, 2012; Gill & Hough, 2007). The organization certifies professionals concentrating in sexuality interventions based upon levels and types of training as Sexuality Educators, Sexuality Counselors, and Sex

Therapists. Unfortunately, although the organization provides a clear definition for sexuality counseling and outlines specific training and practice criteria, these criteria are not intended for masters-level clinicians. Instead, professionals with a graduate degree are required to seek certification as a sex therapist (AASECT, 2012; Southern & Cade, 2011). Traditionally, training in sex therapy focuses on sexual dysfunctions, which may involve medicalized treatment (Southern & Cade, 2011). When the counseling perspective of sexuality is based upon a holistic and developmental experience, counselors may not be comfortable embracing interventions from such a contrasting theoretical foundation (Gill & Hough, 2007; Jackson, 2010).

The Current Study

Addressing sexuality concerns with clients at some point is inevitable for all counselors, regardless of concentration (Fyfe, 1980). To resolve the inconsistent messages regarding sexuality and to clarify the profession's sexual values and efforts in providing effective sexuality counseling, discussion is needed with regards to counselors' current perceptions of sexuality, stemming from their own personal histories, as well as received societal and professional messages (Gill & Hough, 2007; Hays, 2008; Rohleder, 2010; Tiefer, 2006; Toporek, 2011; Trimble, 2009; Weerakoon, Sitharthan, & Skowronski, 2008). To further understand potential developments with regards to sexuality counseling, it is necessary to examine counselors' experiences providing sexuality counseling. This pilot study will attempt to do that.

Materials and Methods

Design

A phenomenological qualitative design was utilized to access the experiences of counselors addressing sexuality concerns with clients. Emphasis was placed upon the meaning associated with the constructs "sexuality" and "sexuality counseling."

Participants

Participants were accessed using Stratified Purposeful Sampling, followed by snowball sampling. There were a total of six participants who met the criteria and were able to participate in the study. Specific criteria shared by participants included being professionally licensed and reporting to have addressed sexuality topics (issues) with more than one client. Demographics were collected relating to participants' ethnicity, gender, age, highest degree earned, and work setting (see Table 1). Of the six participants, one was a school counselor and five were mental health counselors. All of the participants were Caucasian. Five participants were female, and one was male. Two participants were between 30-39 years of age; one was between 40-49 years; one was between 50-59 years; and two were over 60 years of age. Most participants resided in North or South Carolina, and one resided in Iowa. Their work settings varied among participants. Three participants worked in a private practice; one worked in a day treatment program; and the remaining two participants worked in a clinical program within a school setting. Years of post-licensure experience varied among participants, with three reporting less than five years; one reporting 5-10 years; one reporting 10-15 years; and one reporting over 15 years of experience. Three of the six participants reported feeling "very comfortable" with addressing sexuality; one reported feeling "moderately comfortable;" one reported feeling "fairly comfortable;" and one reported feeling "not comfortable."

Data Collection/Interviews & Focus Group

The study took place through the facilitation of one online focus group discussion and two individual interviews with participants who had scheduling conflicts for the group discussion. The site was not comprised of a physical location; rather, a designated website accessed at the scheduled time. Factors in the site selection process included ease of navigation for the facilitator and participants, cost, and security.

Data was collected during a synchronous discussion facilitated with participants via a secure internet conferencing and networking site (www.24im.com), for which participants attained access using a code provided by the researcher. The focus group discussion took place over a two-hour time period and included six interview questions. Individual interviews took place with separate participants during the following week over a one-hour time period and included the same six interview questions. Data was transcribed into a Microsoft Word document verbatim, after which the documents were saved in a secure, web-based online storage service that was password protected.

Following recruitment, participants were provided with additional information regarding the purpose and format of the study through a letter of invitation to participate in the study and an informed consent. In addition, informed consent was implied at several points in the study, to include: responding to the invitation to participate by logging onto the site, posting responses to the site, and answering the question: "Why are you interested in participating in this study?" (Kenny, 2005). Participants were expected to log on to the focus group/interview at the scheduled time and respond to each question accordingly. Data also included follow-up questions by the researcher and/or other participants throughout the discussion. Questions that were posed during the study included: How would you define "sexuality"?; Talk about a recent experience you had providing counseling when sexuality came up; How does your definition of sexuality impact your work with clients/students?; What influenced your perspective of sexuality?; Compare your current perspective of sexuality to before you became a counselor; and Describe your thoughts about sexuality counseling/training.

Data Analysis

The researcher enlisted the assistance of two additional qualitative researchers in the coding process. The coding process followed the interpretative phenomenological analysis (IPA) approach, a well-established technique for data analysis that has been both used in individual interviews and modified and implemented in the analysis of focus group data (Palmer et al., 2010). After reflecting on researchers' preconceptions of the construct under investigation, the researchers followed six steps of analysis, with steps one through four focusing on each participant. The first step involved reading through the transcript without making notations. The second step involved identifying what the participants identify as important, with particular attention focused on the language and meaning used in the discussion/interview related to sexuality. In the third step, emergent themes were identified. In the fourth step, the researchers examined connections across themes. The fifth step of analysis involved repeating the analysis with the next case. Finally, the sixth step involved identifying patterns across participants regarding sexuality (Smith, Flowers, & Larkin, 2012).

Results

The findings support four overall themes present in counselors' perceptions of their experiences of "sexuality" and "sexuality counseling." These themes were (a) sexuality is multi-dimensional, (b) sexuality is developmental, (c) sexuality counseling is dialectical, and (d) sexuality training is insufficient. Within the last two themes, sub-themes were noted. Three dialectical patterns were noted in the theme of dialectics of sexuality counseling, including wellness/dysfunction, subjectivity/objectivity, and flexibility/structure. The insufficiency of sexuality counseling training included a diminished impact of counselors' sexuality training and thoughts on sexuality training in counselor preparation.

Sexuality is Multi-dimensional

All participants agreed that there were various distinct elements of sexuality inclusive within the construct, with layers falling within those elements. Counselors unanimously focused on healthy, developmental aspects of the construct, using expressions such as the ability to "interact on a physical, emotional, and spiritual level to procreate, connect or have deeper experiences of play" (Jane) or "an attraction to another person through sensation or responses; a desire or interest in others" (Susan). In the focus group, the conceptualization of sexuality appeared to expand from original responses as seen in the following excerpt:

John: Concur that [sexuality] involves physical, emotional and spiritual aspects (plus more) but should also be more than attraction or connection. There should be some aspect of sensual or erotic to be regarded as sexuality.

Jane: And what Susan added of course can lead to social realms too.

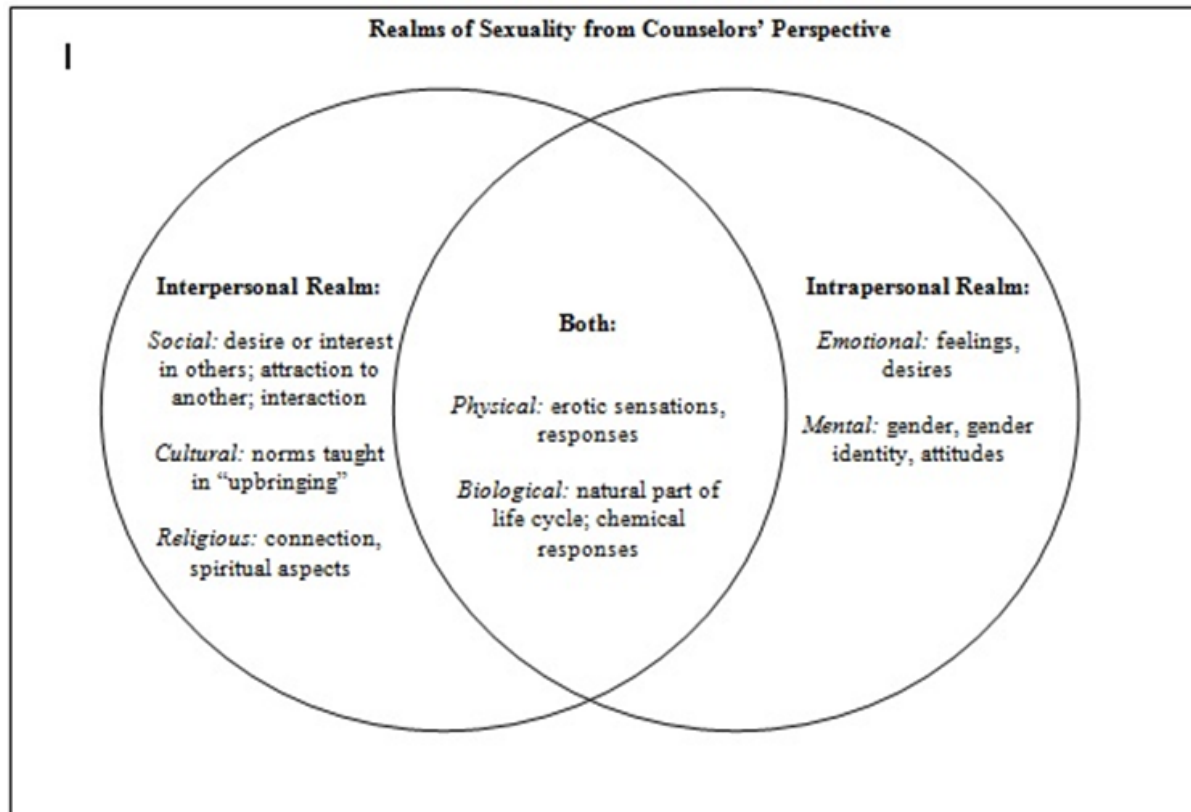
Jane: I guess in response to John, yes, good point. It has a more specific physical reaction and oxytocin etc. than any physical play

Susan: sexuality does not have to be just a connection with someone else. It can be explored through our own connection with self through masturbation.

The multi-dimensional nature of sexuality can be placed along a dialectical continuum, with aspects falling within interpersonal and intrapersonal realms and some aspects found, to a degree, in both (see figure 1). The interpersonal realm included such aspects as social, cultural, and religious experiences related to sexuality. One counselor highlighted that sexuality involves "an attraction to another person through sensation or responses, a desire or interest in others" (Susan), and another counselor stated that sexuality is "the part of ourselves that can interact on a physical, emotional and spiritual level to procreate, connect or have deeper experiences of play" (Jane). In contrast, the intrapersonal realm included the emotional and mental aspects of sexuality. One counselor stated that sexuality is "all your feelings, attitudes, desires and experiences towards sex" (Jennifer), and another stated "it also can include gender, gender identity, sexual orientation, in addition to the emotional and spiritual" (Susan). Aspects of sexuality that involved both the intrapersonal and interpersonal realms included physical and biological experiences of sexuality, as noted by one participant who stated "it is biological and a natural part of our life cycle" (Susan). Another participant who emphasized "the capacity for an individual to have sensual and/or erotic sensations, experiences and responses" (John).

The complexity of sexuality became more evident as participants attempted to integrate responses to subsequent questions into their conceptualization of sexuality.

Figure 1
Realms of Sexuality from Counselors' Perspective

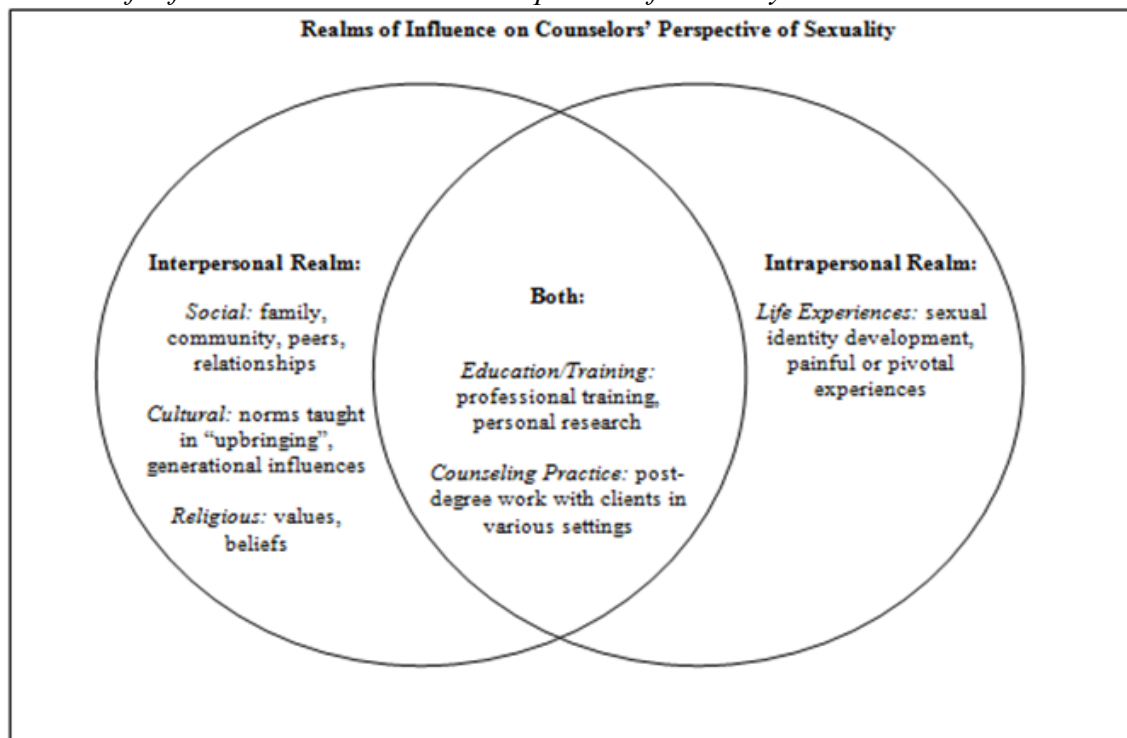


All participants indicated that influences, like aspects of sexuality, are multi-dimensional as well. Influences could also be categorized in interpersonal and intrapersonal realms, with some influences falling in both (see figure 2). The interpersonal realm of influences involved both social factors—such as family, community, and relationships—and cultural factors—such as religion—“upbringing,” (as labeled by two participants) and generational aspects. One counselor stated, “I grew up in the 50's and early 60's when it was expected that good girls would be virgins until marriage and not talk about sex—my mother gave me a book to read about puberty—I didn't ask any questions!” (Mary). Another counselor stated that her influences included “first the Catholic Church, then definitely my social environment. Then my relationships” (Jane), and a third counselor emphasized the importance of “my family and community” (John). The intrapersonal influences on counselors' perception of sexuality included unique life experiences, which may have included identity development, as well as pivotal or painful experiences. One counselor highlighted that “being sexually molested as a child and not being protected by my parents, the people I knew in college helped and working with a therapist to deal with all of it helped greatly” (Susan). Another counselor emphasized the importance of exposure in the process of her own sexual identity development when she stated “although I am not homosexual, I've been to many clubs/bars with others who are and been privy to their world from friends' first hand experiences” (Jennifer). Influences that involved both interpersonal and intrapersonal realms included professional training and clinical experience, which were viewed as less influential than the other two realms by participants. Mary stated, “Of course, education

was a major influence—as I entered the helping fields I quickly learned that sexual energy was part of everything.” John mirrored the impact of clinical experience when he said, “After graduation and when the clinicians start practice is when we realize we are not well equipped for much of what comes into the office.” Intrapersonal experiences appeared to be significantly influenced by interpersonal factors.

Figure 2

Realms of Influence on Counselors' Perspective of Sexuality



Sexuality is Developmental

Four of six participants regarded sexuality as developmental in nature, with changes that occur over time: sometimes as a result of the stage of life, sometimes due to social and community influences, and sometimes as a result of significant events or experiences. In an individual interview, Mary responded to the question about the influences on her perception of *sexuality*:

Mary: My upbringing was fairly traditional Southern - I didn't have any traumatic sexual experiences as a child or adolescent.

Researcher: Could you expand on "fairly traditional Southern" and what that means related to sexuality?

Mary: pretty interesting term, isn't it? I guess I mean that....

Mary then provided more details regarding social changes in her generation that impacted her perception.

Mary: The Times were A'Changing in the 60's, and I was very much a part of that movement—The book *Our Bodies, Ourselves* was amazing! Of course, education was a

major influence—as I entered the helping fields I quickly learned that sexual energy was part of everything.

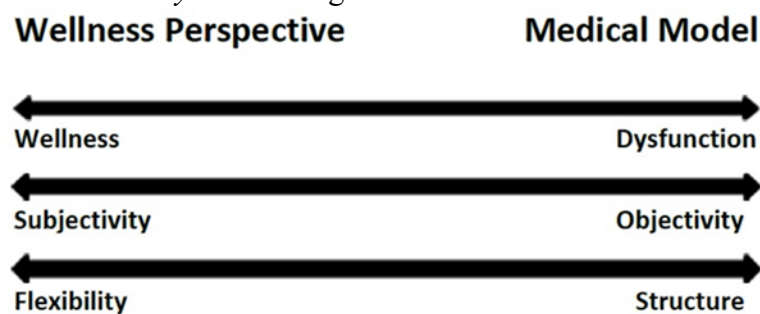
Participants emphasized in addition to being a “natural part of our life cycle” (Susan), it is “a positive part of our development as full humans” (Jane). While discussing counseling interventions, participants also shared the experience of not being “surprised when issues related to sexuality emerge because at the end of the day sex is part of most life experiences” (Mary), and “I also feel sexuality continues throughout your life so this helps to work with parents and children” (Ann).

Participants also viewed influences on their perception of sexuality as developmental. They valued the continuing nature of changes regarding their views on sexuality as they encountered new people and experiences in both personal and professional contexts. One counselor stated that he is “still having my perspective influenced” (John), and another counselor added “I think we are constantly learning and having our perspective on sexuality influenced” (Jennifer). Mary specifically connected her perspective to her clinical experience when she said, “My perspective continues to change as I become more invested as a therapist.”

Sexuality Counseling is Dialectical

All participants demonstrated dialectical tensions when providing sexuality interventions that were not as apparent when they discussed their conceptualization of the construct. The application of their view of sexuality in counseling appeared to be a struggle for these counselors. The dialectical tensions fell within three distinct patterns: balancing a personal definition of sexuality based on wellness with addressing dysfunctional sexual behaviors in clients; honoring their subjective experiences regarding sexuality while remaining objective as a practitioner; and balancing flexibility with providing structure for clients.

Figure 3
Dialectical Tensions in Sexuality Counseling



Wellness and dysfunction

In spite of defining sexuality in developmental and wellness-based terms, most clinical examples highlighted dysfunctional sexual behaviors, with four of six participants highlighting a wellness-dysfunction dialectical tension in their practice. One counselor shared:

I have a client who is a sex addict and talking about healthy sexuality and what that means within his relationship. How to express sexuality without getting triggered into his addiction and the ability to explore in a healthy way (Susan).

Jennifer presented the case of an 11-year-old male client, who had been sexually abused from age of 4-5 by multiple individuals. He is trying hard to form attachments to females in his life, and is starting to hit puberty and considers himself a 'monster' based on past abuse. Another manner in which this dialectic presented involved the importance of addressing sexuality within the context of other life dimensions, regardless of the presenting issue in counseling. Mary stated of her experience: "The most recent was with a female, in her late 40's, in a relationship with a man who has ED due to a serious medical (degenerative) issue. The woman does not care that he can't have an erection but he feels like he has lost his manhood and is hesitant to even try."

Ann focused on systemic and developmental aspects with two sisters who are struggling with their sexual identity. One identifies as gay, the other not sure, maybe bi. We discussed what each one of these IDs meant to them. We also explored mother's sexual identity and what it meant to her for her daughters to ID with something else.

It appeared that the application of counselors' conceptualization of sexuality as a healthy aspect of development became complicated when working with clients if other factors, such as relationships, dysfunction, abuse, and shame were involved.

Subjectivity and objectivity

Five out of six participants sought to teach clients about healthy sexuality while keeping their personal definition out of the sessions. John shared, "I do not see it as much about my definition of sexuality as much as my support of what is healthy and appropriate for the clients in their life and relationships," and Susan stated "I let my clients define sexuality and use their definition. I will also help them explore what sexuality can include. I try to keep my definition out of the process." Participants also expressed tension in balancing self-awareness with focusing on the client. Jane expressed strong emotions regarding the perception of one client's family members regarding the client's sexuality when she stated:

Of course incest seems to be on God's OK list!!! Sorry. I get bitter about our clients' families sometimes. Just saying that that (sexual abuse) was a part of her history, and it is specifically the fact that the letter was to a female that is upsetting to them.

Another participant expressed similar difficulties when she shared:

I tried, of course, to remain detached from that but honestly found them fascinating. I am OK with polyamorous and kinky choices and found it interesting how they used Scripture to defend it all. Not an argument you hear often. Sometimes it was hard not to ask a bunch of questions and stay focused on the identified problem. (Jane)

Another counselor identified that her struggle was specific to a particular sexual issue. Susan said, "the only client that I have difficulty with was a perpetrator. I enjoy the exploration of sexuality with other clients. Finding out their definitions, morals, beliefs and try to keep my beliefs out of the counseling arena." In response to Susan's disclosure about difficulty remaining objective with perpetrators, John responded, "Susan, that is why I recuse myself from working with perps. The same with domestic violence perps. I struggle with objectivity in those areas."

Finally, participants struggled balancing being authentic with maintaining professional boundaries with clients. Jane shared “I definitely walk a line though since I am school-based and working with minors from very conservative rural families.” For Mary, it appeared that anxiety regarding this dialectic was minimal. She said “Based on my definition sexuality is not usually a separate issue but is integrated into many life issues.” All participants expressed having some degree of difficulty at some point in their professional development.

Flexibility and structure

Five out of six participants emphasized valuing the clients’ perception while also providing guidance regarding healthy sexuality. One counselor stated that her flexibility allowed her to provide structure for clients when she stated, “I feel being open and fluid in the definition as it means different things to clients helps me focus on what is impacting them and what they are wanting to work on or change” (Jennifer). The degree of flexibility and structure varied based upon the developmental stage of the client. John stated, “With adolescents, the more concrete, the better. They struggle with abstract concepts and relationships. However, sexuality and relationships are very abstract and fluid. That causes problems in treatment and understanding.”

Sexuality Training in Counseling is Insufficient

Overall, participants indicated some form of external guidance in the area of sexuality. Half of the participants indicated taking a graduate course in sexuality, and half indicated that their knowledge was acquired through independent, informal research. Half of the participants reported addressing sexuality in supervision, and over half (67%) had attended a workshop or presentation. Counselors noted the insufficient impact of their training in sexuality and the need for further training in this area.

Insufficient training

Four out of six participants reported degrees of an insufficient impact of training to prepare them for practice in sexuality counseling. Jennifer stated, “I’ve always been open to learning more before and after becoming a Counselor so nothing has changed for me in my perspective.” Minimal change was indicated by Susan, who shared, “I believe I have opened and broadened my views of sexuality in some ways, I have always been very accepting of sexuality. However, being a counselor has taught me a few things that I did not know in some areas of sexuality.”

Participants viewed that counseling practice had more of an impact than their training in sexuality counseling. Mary said,

As I entered the helping fields I quickly learned that sexual energy was part of everything. ... After I entered the counseling field I discovered that sexual problems/issues were usually part of other aspects of life and could not usually be dealt with independently or compartmentalized.

Ann expressed, “I think I have always been open to sexuality not frightened by it but I think the difference is now I truly see how much it impacts a person’s life.”

Need for more sexuality training

All participants also emphasized the need for further training in the counseling field. John stated “There is not enough training in our graduate programs. Difficult to include since that is

not a requirement for licensure or graduation.” In addition to expressing the need for increased training, counselors expanded to emphasize the importance of integrating that training across master’s preparation. Mary shared:

I think sexuality counseling/training needs to be integrated into all counselor ed courses, just like we do with diversity issues—counseling students must be clear about their own sexuality issues in order to maintain healthy boundaries with those who may be struggling in this area—and of course we need much more research in this area!

Ann mirrored this opinion when she said:

All clients in clinical school settings, whatever the setting is, have a need to learn speak about and grow from discussion about sexuality. This change needs to begin in the training programs for counselor. Help them to embrace and have the skills set to go out in their profession and work with sexuality issues, normative or abnormative.

The importance of positive role modeling and mentoring was also mentioned through discussion of examples of poor leadership in the profession regarding sexuality. Jennifer said, “In my graduate program we had one class that was taught by someone that opened the first class by saying “I am not comfortable with teaching this but had no choice.” John shared a similar experience in his graduate course when he responded, “In my graduate course, the instructor admitted that he was teaching it to help determine why his wife left him for a woman and if we could help him figure it out.” Ann shared the possible impact of generational influences on sexuality training when she stated, “Counselors that have been the grandfathers and grandmothers of this profession most likely did not have parents who spoke a lot about sexuality to them.”

Additional Considerations

One participant highlighted the importance of increasing research related to sexuality counseling. In spite of this emphasis not being sufficient enough to be reflected in the themes, it is of particular interest to this study, given the difficulty in recruiting participants for the study. In spite of hundreds of invitations sent out, only six participants volunteered to participate in the study. The participants that did volunteer for the study were open to discussing sexuality with their clients, and this willingness may not be reflective of counselors overall.

Discussion

Movement Toward a Constructivist Perspective.

Because sexuality is a universal human experience, counselors are guaranteed to be confronted with it at some point in their careers (Fyfe, 1980), but because of its complexity, counselors need to take multiple theories and viewpoints into account when assessing and addressing sexuality (Long, Burnett, & Thomas, 2006; Mallicoat & Gibson, 2014). Traditionally, sexuality has been viewed from a binary perspective (i.e. male/female, dysfunction/function, deviant/normal) (Lazarus, 2008). However, the themes resulting in this study indicate that counselors view sexuality as a much more complex construct, consistent with trends in recent literature. Recognizing sexuality as multi-dimensional, counselors express valuing a shift toward a more holistic lens in sexuality counseling (Diamond & Hubener, 2012; Elders, 2010; Gill &

Hough, 2007; Southern & Cade, 2011; Tiefer, 2006; Trimble, 2009). Diversity in sexual expression includes facets within interpersonal and intrapersonal realms, influenced by experiences, culture, social networks, and stages of life. While the interaction of these realms impacts sexual expression, sexuality itself is a universal experience (Dupkoski, 2012). As our perspective shifts, the sexual response cycle is no longer sufficient to examine the sexual experiences of our clients and determine whether an individual's sexual behavior or response is healthy. Medical interventions, which have become the default protocol in our modern society, are not always appropriate or sufficient to increase sexual wellness. Indeed, the DSM 5 has already made some changes from basing sexual difficulties on this model (APA, 2013; Mallicoat & Gibson, 2014), indicating that the paradigm shift in the Counseling profession may also be mirrored in other mental health disciplines as well.

Sexuality Counseling's Identity Confusion

"Sexuality counseling" is a term that has been used across disciplines, making the definition unclear (van der Kwaak, vanKatz, & Dielman, 2010). Therefore, counselors need to clarify what sexuality counseling is and what it entails within the counseling profession. According to the accreditation protocol of AASECT, a professional with a graduate degree must apply to become certified as a sex therapist rather than a sexuality counselor. However, the process requires a significant amount of post-graduate time and money that counselors may not be willing or able to invest for training and supervision that involves training in addressing sexual dysfunctions and is the equivalent of getting a doctoral degree (AASECT, 2012; Gill & Hough, 2007; Southern & Cade, 2011). Because these counselors perceived sexuality as a developmental experience, the focus of sexuality counseling within the counseling profession would emphasize developmental experiences and educating clients about normal, healthy sexual functioning.

Clarification within the profession would decrease the burden of becoming proficient when addressing sexuality with clients and provide structure regarding—what information is provided to clients and the limitations of counselors when addressing sexuality. First, a shift in language needs to take place to differentiate sexuality counseling from sex therapy. Indeed, in the current study the participants did not have a shared language to express their experiences with clients. This language should be based on developmental experiences, refrain from judgment, and enhance clients' willingness to discuss sexuality openly. From a constructivist perspective, sexuality counseling is about more than highlighting multiple aspects of a problem, but emphasizing language leaning toward individual experience and wellness (Dupkoski, 2012).

An Increase in Sexuality Training and Research.

To address the need for further training in sexuality counseling, the counseling profession needs to determine whether sexuality counseling is a core competency or a specialization within the profession. Training should include understanding theories and perspectives of sexual behavior, exploring influences on sexuality, cultural implications of sexuality, assessment of sexual behaviors, and sexuality counseling interventions. Based upon whether sexuality counseling is considered a specialty or a core competency, graduate level training can include: incorporating training throughout existing courses as part of the CACREP competencies; developing a concentration or certification within the field (to avoid labeling/identity

issues/cost/etc.); or requiring that all counselors take a sexuality counseling course as part of mandatory training.

In addition to increased training, it is advantageous for counselors to increase participation in sexuality counseling research within the counseling profession. Doing so will serve to further clarify the profession's perspective of sexuality counseling and enhance sexuality interventions overall. Currently, most research on sexuality counseling is focused in the rehabilitation counseling concentration (Dupkoski, 2012).

Resources to assist counselors in enhancing their competency in sexuality counseling exist, even if they must be actively sought. A basic search on the Internet will provide counselors with information regarding different organizations offering training through courses, workshops, seminars, and conferences. The American Counseling Association offers resources as well, including the Sexual Wellness in Counseling Interest Network, approved in March 2013 (Rudrow, 2013; Mallicoat & Gibson, 2014). This network provides opportunities to collaborate with other counselors regarding consultation, training, and research in the area of sexuality counseling.

Further research is necessary in sexuality counseling to clarify the realms of sexuality and create a definition that can be utilized in sessions with clients. In addition, it would be beneficial to examine counselors' experience and effectiveness providing sexuality counseling and differences between counselors with and without graduate level training preparation. For guidance, finally, more research needs to be conducted on positive, normal, and pleasurable aspects of sexuality and sexual functions. Finally, it would be helpful to focus on school counselors on addressing sexuality due to the legal constraints and lack of licensure requirements.

Conclusion

The themes identified in this pilot study offer insight into how counselors' currently perceive sexuality and sexuality counseling. Counselors' view of sexuality as multi-dimensional and developmental indicates that the Counseling field has a conceptualization of sexuality counseling that is distinct from sex therapy. As such, the profession would benefit from investing in clarifying the nature of sexuality counseling and training counselors in addressing sexuality with clients. There is a need to clarify whether counselors view sexuality as a core competency or a specialization to examine how to increase sexuality counseling training.

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