Sexuality Counseling

Theory, Research, and Practice

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COUNSELING and
PROFESSIONAL IDENTITY

Chapter 1

Addressing Sexuality in Professional Counseling

What is sexuality?
What is your understanding of sexuality?
To what extent does sexuality define people's lives and intimate relationships?

We would wager a guess that if we asked the questions above to ten people, we would hear ten very different responses. We've grown accustomed to the interesting looks and responses we get when we tell people we address the topic of sexuality in our teaching, research, and clinical practice, and the responses were similar when we shared the news with our friends and family that we were writing this book. We need to look no further than these responses to know that sexuality is a topic to which people ascribe a lot of meaning, which gives rise to a range of emotional and attitudinal responses.

We can see the confusion about sexuality at a cultural level as well. On the one hand, sex is virtually everywhere—such as in popular music, advertising, movies, and television. On the other hand, many people are very uncomfortable with even the idea of discussing sex in their most personal relationships, including with their romantic partners and their children. Further, in many geographic areas, there is very limited education about sexuality in school settings (Denehy, 2007). From a family systems perspective, the issue of sex in society is a classic "double bind," in that there are conflicting social messages of "Have a lot of sex" and "Don't have sex or at least not unless you are in a committed or marriage relationship," along with the third message of "Please, *please* don't talk about it!"

Despite their professional training, counselors are not immune to the discomfort surrounding sexuality (Binik & Meana, 2009; Harris & Hays, 2008). Training in sexuality counseling is not required for many mental health professionals (Binik & Meana, 2009; Harris & Hays, 2008; Juergens, Smedema, & Berven, 2009; Kazukauskas & Lam,

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2009; Miller & Byers, 2010; Southern & Cade, 2011), so unfortunately, many counselors enter their professional careers without having any formal education on how to address sexuality-related issues with their clients. Counselors are, of course, human first and as such, they are products of their social and cultural environments, and therefore often experience a good deal of anxiety discussing sexuality (Juergens, Smedema, & Berven, 2009; Kazukauskas & Lam, 2009; Kleinplatz, 2009; Nasserzadeh, 2009). Even counselors who feel generally comfortable discussing the topic often have certain sexuality-related topics that are more anxiety-provoking than others. And yet, how can counselors expect their clients to be comfortable discussing their sexuality-related concerns when they themselves are not comfortable with these topics?

Clients often seek counseling for concerns related to their sexuality, whether as their primary concern or as a secondary concern to more pressing issues (Miller & Byers, 2010; Southern & Cade, 2011). However, many counselors likely do not view sexuality concerns as being within the scope of their professional identities or competence. In many cases, clients' sexuality-related concerns are never addressed or are addressed inadequately. The reasons for this may include that their counselors fail to ask about their sexuality-related concerns, that clients do raise the issues but counselors move on prematurely to discussing other concerns, and/or that clients and counselors fumble through discussing these issues at a surface level but fail to address them with enough depth to produce meaningful change.

For all of these reasons, we believe that sexuality is an essential topic for counselors to become competent enough to address in their work. The scope of the topics included in this book demonstrates the broad range of sexuality-related concerns that clients may bring to counseling. We cannot imagine a clinical setting in which counselors would not have the potential to work with clients experiencing sexuality-related concerns. Therefore, we believe that counselors with any and all specialized backgrounds must have at least a basic understanding of how to address sexuality concerns, either themselves or through referrals to other specialized clinicians.

Our goal in this book is to provide readers with an understanding of these concerns, as well as research- and theory-based interventions for addressing them. This first chapter provides the foundation for the remaining chapters, and we begin this chapter by defining sexuality and providing an overview of the aspects of sexuality addressed later in this book. Then, we discuss key professional issues, including credentialing, the history of sexuality counseling and sex therapy, and important professional competencies. Later in the chapter, we introduce the unique ethical context for sexuality counseling. The chapter concludes with an overview of the remainder of the book. After reading this chapter, readers will be able to do the following:

a. Describe the Contextualized Sexuality Model
b. Understand the historical context surrounding sexuality counseling

   c. Delineate the distinctions between sexuality counseling and sex therapy

   d. Discuss key ethical considerations for doing sexuality counseling

DEFINING SEXUALITY

One of the most comprehensive and widely cited definitions of sexuality is the following one put forward by the World Health Organization (WHO; World Health Organization, 2010):

> Sexuality is "a central aspect of being human throughout life (that) encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors." (p. 4)

This definition shows that sexuality is far broader than many people initially assume. Further, the term *sexuality* is inclusive of, but not limited to, the physical act of sex and sexual orientation. The WHO (2010) definition of sexuality also emphasizes that sexuality is a very individual aspect of people's lives. Given all of the varying influences upon sexuality, each and every person expresses his or her sexuality in a unique and personalized manner.

A COMPREHENSIVE, CONTEXTUAL FRAMEWORK FOR UNDERSTANDING SEXUALITY

Several scholars advocate for a comprehensive, integrative, multidisciplinary approach to understanding human sexuality (e.g., Bitzer, Platano, Tschudin, & Alder, 2008; Levine, 2009). As such, this book is grounded in the comprehensive, contextual conceptualization of human sexuality that is presented in Figure 1.1. We refer throughout this book to this framework, which we call the *Contextualized Sexuality Model*, as an organizational framework for understanding the diverse influences on the sexuality-related issues that clients bring to counseling. This model holds that sexuality is a core component of human life, and it is embedded within numerous contextual influences. As shown in Figure 1.1, the contextual influences on human sexuality that will be discussed through the rest of the book include physiology, developmental influences, psychology, gender identity and sexual orientation, intimate relationships, cultural

Figure 1.1 The Contextualized Sexuality Model
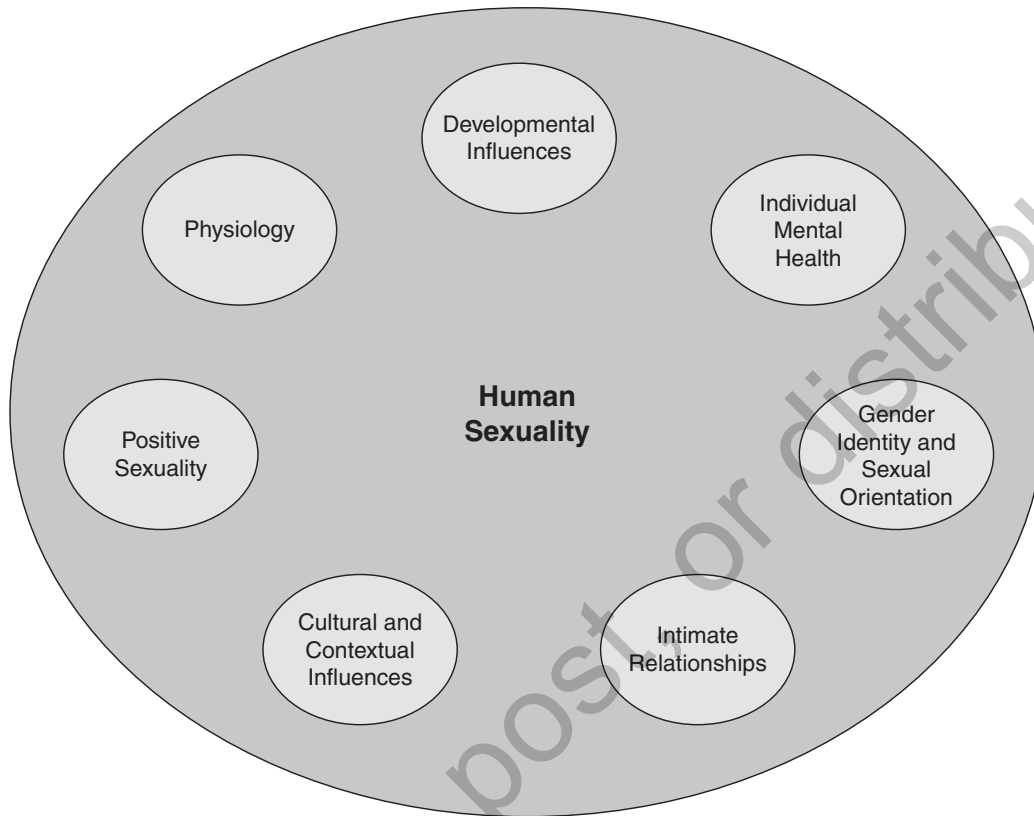
and contextual influences, and positive sexuality. These influences are reciprocal, in that each one impacts a person's sexuality, and likewise, one's views of and experiences with sexuality can impact growth and development in the contextual areas.

Although we depict each contextual influence as an independent entity, the influences are interactive and are combined in unique ways for each person. For example, one's sexual orientation cannot be understood fully without consideration of such other influences as how that sexual orientation is viewed within the client's significant cultural and social relationships or how the person expresses his or her sexual orientation within intimate relationships. We developed the Contextualized Sexuality Model to be adaptable to clients' unique needs and circumstances. We assume that clients will vary in the extent to which each contextual influence is at play in the sexuality-related concerns that they bring to counseling. For example, consider the following three case examples, all depicting scenarios of couples presenting for counseling related to conflict over disparate levels of sexual desire between partners.[*]

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[*]All case illustrations in this book are fictional and not based on any real individuals. They were imagined to illustrate the points being made in the text.

CASE ILLUSTRATION 1.1

THE CASE OF SUSAN AND KENT

Susan (age 32) and Kent (age 33) recently had their third child. The pregnancy and delivery were difficult for Susan, and she feels overwhelmed by the responsibilities of caring full-time as a stay-at-home mom to the couple's three children. Kent works long hours as an emergency room physician. Now that the baby is 2 months old, Kent was hoping the couple would be enjoying sexual intimacy again, but Susan admits that she has no desire for sex because she is too exhausted from her parenting responsibilities. She says, "I just don't have anything left for Kent."

CASE ILLUSTRATION 1.2

THE CASE OF JOANNA AND STEVE

Joanna (age 48) and Steve (age 45) have been married for five years, and it is the second marriage for each partner. They have no children, and both enjoy busy and fulfilling jobs. However, Steve is currently being treated for depression, and his treatment includes monthly meetings with a counselor and an antidepressant medication. Steve reports that, since he was diagnosed with depression and began the medication, he has lost any interest in sex. Joanna reports that she is frustrated and would like to have a sexual relationship, but she says that she just turns her focus to her work to keep her mind off of her frustrations while Steve is being treated.

CASE ILLUSTRATION 1.3

THE CASE OF ELENA AND SOPHIA

Elena (age 65) and Sophia (age 64) are a lesbian couple who have been together for 20 years. The couple reports that they share a loving, stable relationship and feel supported and loved by their network of family and friends. They are seeking

counseling because they are both nearing retirement and are concerned about the stress this transition may bring to their relationship. They indicate that one of their major concerns is the impact that this transition will have upon their sexual relationship. Both partners state that they view the physical, sexual intimacy they share as an important avenue for growing their relationship and fostering personal growth. However, because for the past several years Elena's level of sexual desire has grown increasingly greater than Sophia's, they are concerned that this will be an area for conflict once they end their careers and have more free time available.

Although each of these couples in the cases above are presenting for counseling with a similar underlying issue—one partner has a higher level of sexual desire than the other partner—the dynamics of their relationships and concerns in counseling are very different. Although all of the influences in the Contextualized Sexuality Model are likely at play to some degree in each couple's situation, certain themes are likely to be more prominent for each couple. For Susan and Kent, the most prominent influences are likely the developmental transition to expanding their family, the physiological effects of pregnancy and childbirth for Susan, and the dynamics of their intimate relationship. For Steve and Joanna, Steve's mental health appears to be a primary influence, as well as likely the physiological impacts of his antidepressant medication. And finally, for Elena and Sophia, their intimate relationship patterns over the past several years are likely interplaying with their views of the importance of sexuality for promoting positive relationships and personal growth as they figure out how to adapt their sexual relationship to their new phase of life in retirement. Of course, if we knew more details about each couple, it is likely that we would find other influences at play as well. Nonetheless, these cases demonstrate how the complexity of clients' sexuality concerns can be understood best within the broader framework of contextual influences. Before we move on to addressing professional considerations for sexuality counseling, we provide a brief introduction to each of the categories of influences in the Contextualized Sexuality Model.

Physiology

Sex and sexuality have their origins within the body, from the anatomical body parts that determine one's biological sex, to the physical touching and connections involved in intimacy with another person, and further to the physiological requirements of human reproduction (Althof, 2010; Bitzer et al., 2008; Levine, 2009). Many counselors lack intensive training in biology and anatomy, and therefore, this aspect of sexuality can be intimidating to many counselors and counselors-in-training. Nonetheless, physiological components are essential for

understanding human sexuality, and therefore, counselors should equip themselves with a basic understanding of the physiological underpinnings of human sexuality. For example, a counselor working with a female concerned about her ability to become aroused to orgasm would need to understand the basic physiology surrounding female sexual functioning, as well as be comfortable discussing this client's functioning and attitudes toward that functioning as part of the counseling process.

Developmental Influences

Human sexuality can be viewed as a lifelong process that grows and evolves as people move through various developmental phases in their lives and relationships. Expectations surrounding people's sexuality often begin even while in the womb— such as through the gender expectations that arise when parents learn their baby's sex and through comments that people often jokingly make about the possibilities for the baby's future (e.g., "Someday your daughter can marry my son so we can be family!"). Sexuality in childhood often takes the form of curiosity, exploration, and many, many questions. Parents and educators often struggle with how best to talk with children about their emerging sexuality. Sadly, rates of childhood sexual abuse remain high, and therefore, some children's experiences with sexuality are impacted by their experiences of abuse.

As individuals progress through adolescence and young adulthood, their emerging sense of themselves as sexual beings continues to evolve as they navigate dating, intimate relationships, and realities about the potential consequences of sexual activities (e.g., sexually transmitted infections [STIs] and unplanned pregnancies). Throughout all of adulthood, people grow and change in their sexuality in unique and individualized ways. Although older adults are often stereotyped as being non-sexual, many adults continue to enjoy a healthy sense of sexuality throughout their entire lives. Overall, then, it is important for sexuality counselors to understand common sexuality-related developmental transitions, challenges, and opportunities that people face and how these impact clients' concerns in counseling (Althof, 2010).

Individual Mental Health

A person's overall mental health is closely intertwined with his or her sexuality (Bitzer et al., 2008; Levine, 2009). Sexuality is one avenue through which people express their beliefs, values, feelings about themselves, and body image (Juergens, Smedema, & Berven, 2009). Therefore, one's sexuality can impact one's mental health, and one's mental health can impact one's sexuality. For example, a client presenting with depressive symptoms may report a loss of interest in sexual activities, and this loss of interest in sex may also bring about anxieties about

one's sexuality and relationships. Indeed, researchers have demonstrated common links between mental health disorders and sexual functioning. In addition, the Diagnostic and Statistical Manual of Mental Disorders (DSM-V; American Psychiatric Association, 2013a) contains sections on sexual dysfunctions and gender dysphoria, and therefore, a category of mental disorders relates directly to sexuality-related concerns. Further, there is growing recognition of the links between addiction and sexuality, including sexually compulsive and addictive behaviors. In addition, the mental health consequences of trauma, whether related to sexual abuse or other forms of trauma, can impact clients' sexuality. Therefore, individual mental health functioning is an important contextual area for understanding human sexuality.

Gender Identity and Sexual Orientation

Sexuality is undoubtedly impacted by how people view their gender and sexual orientation. Gender identity encompasses not only whether one views him- or herself to be male, female, and/or transgender but also the meanings the person ascribes to that gender role (Juergens, Smedema, & Berven, 2009). Therefore, counselors can make no assumptions about what it means for someone to be a woman, man, or transgender person in society today. Likewise, sexual orientation is a more complicated construct than a categorical view (i.e., straight, gay, lesbian, or bisexual) that this construct implies. For example, Holden and Holden (1995) described the Sexual Identity Profile (SIP), which demonstrates that people's sexual identities are far more multidimensional than commonly thought. The SIP suggests that people define their sexual identities along five continuums, falling somewhere between homosexual and heterosexual on the following five dimensions: (a) sexual orientation (i.e., toward which sex one is erotically attracted), (b) sexual attitudes (i.e., one's beliefs about which sexual orientations are acceptable or unacceptable), (c) erotic behaviors (i.e., the sex or sexes with which the person engages in sexual behaviors), (d) public image (i.e., how others perceive one's sexual orientation), and (e) nonerotic behaviors (i.e., the sex or sexes with which the person uses non-sexual forms of interaction and touch, such as handshakes). Holden and Holden asserted that the ideal profile, meaning the one that would most likely lead the person to feel a sense of congruence about his or her sexual identity, is one in which the person falls at similar points along the first four dimensions and falls near the center along the fifth continuum. In other words, a person with a congruent profile would understand the sex(es) that are erotically attractive, believe that this sexual orientation is acceptable, engage appropriately in sexual behaviors that are consistent with his or her sexual orientation, and be accepted by others as having that sexual orientation, and yet they would feel comfortable interacting and engaging with others regardless of gender. Therefore, it is important for counselors

to understand not only the labels that clients ascribe to their gender and sexual orientation but also how their gender identity and sexual orientation fit within the broader social and individual context (Bitzer et al., 2008; Levine, 2009).

Intimate Relationships

Relationship functioning is an important aspect of sexuality (Althof, 2010; Bitzer et al., 2008; Levine, 2009). Sexual activity often occurs within the context of an intimate relationship, and so the health and dynamics of that relationship contribute to how sexual and relationship partners experience sex and sexuality. Common folklore holds that "Sex is the glue that holds partners together," and also that "Sex is a barometer of how things are in other areas of a couple's relationship." Although there may be some truth to these statements for some couples, counselors must set aside the assumptions that they hold about the role of sex in intimate relationships, as clients will vary widely in their sexual attitudes, behaviors, and practices within their relationships. For some couples, sexual intimacy is a primary vehicle for connection, but other couples place a much lower value on physical intimacy and may achieve intimacy in various other ways. Further, some couples cannot engage in sexual behaviors, such as when physical health conditions or disabilities prohibit this form of sexual expression. Relationships can come in many forms, from casual dating relationships to monogamous partners, to marriage and domestic partnerships, to open and polyamorous relationships. The meaning and functions of sexuality within clients' intimate relationships are important for understanding how clients express and view their sexuality.

Cultural and Contextual Influences

Tiefer (2009) defined sexuality as

a socially constructed realm of human experience composed of interpersonal conduct, psychomotor learning, cultural attitudes and values, and physical function. Because of its connections to social location, reproduction, and pleasure, sexuality is first and foremost political, as witness the history of monitoring and regulation in all cultures. (p. 1046)

Tiefer's (2009) perspective on sexuality contrasts with many common assumptions that sexuality begins with the physical components and our goal is not to determine which perspective holds the most truth. However, Tiefer's commentary on the political nature of sexuality provides an important reminder that sexuality always occurs within social contexts, and those social contexts influence the norms and rules that determine how clients express their sexuality. These contextual

influences include ethnicity and culture, but they also extend to religion and spirituality, socioeconomic factors, geographic influences, and the influences of the media (Althof, 2010; Bitzer et al., 2008; Levine, 2009; Juergens, Smedema, & Berven, 2009).

Positive Sexuality

The notion of positive sexuality suggests that sexuality can provide an important avenue for personal and relational growth and that healthy sexuality is not merely the absence of sexual problems and dysfunctions. Although positive sexuality is inherently linked to all of the other areas discussed above, we believe it is important to consider it as a unique context for understanding human sexuality. Historically, much of the emphasis on sexuality within the mental health professions has focused on the treatment of sexual dysfunctions and other problematic areas of clients' expression of their sexuality. However, as we discuss in Chapter 10, a new view is emerging that provides a more positive lens for understanding the roles that sexuality can play in people's lives. Clients need not be experiencing sexual difficulties to benefit from addressing their sexuality within counseling. Rather, clients' expressions of their sexuality can provide insights and opportunities for enhancing their personal development and achieving greater connectedness and fulfillment within their intimate relationships.

PROFESSIONAL ISSUES IN SEXUALITY COUNSELING

The area of sexuality counseling raises many questions for counselors, including how sexuality counseling differs from sex therapy, whether additional credentials are required, and what constitutes professional behaviors and competence when practicing in this area. These issues can best be understood within a historical context, and we begin this section by reviewing key historical developments that impact sexuality counseling practice today.

The Historical Context

Perspectives on human sexuality within the mental health professions have shifted significantly over time. Some of the earliest views on sexuality were proposed by Freud, who viewed sexual feelings as reflective of internal psychological conflicts (Goodwach, 2005a; Southern & Cade, 2011). However, sexuality remained relatively under-studied until Alfred Kinsey began his high-profile research in the 1940s and 1950s (Goodwach, 2005a; Southern & Cade, 2011), which challenged many predominant norms about sexuality and especially female

sexuality. Following this and led by the work of William Masters and Virginia Johnson, sex therapy was predominantly focused on behavioral approaches to address sexual dysfunction (Goodwach, 2005a; Southern & Cade, 2011). The term *sex therapy* was first used in the 1950s by Masters and Johnson, although it was not used widely until the 1970s (Binik & Meana, 2009). Around this same time (i.e., from the late 1950s to the 1970s), the American culture at large also experienced a significant period of sexual exploration and experimentation (Goodwach, 2005a). This resulted in a range of humanistic approaches (e.g., surrogate partners, nudism, mind-body approaches, and counselors using sexual touch with clients) (Tiefer, 2006), many of which are no longer accepted as professional or ethical today.

Early sex therapy in the 1970s focused on dysfunction-specific treatments that typically integrated educational approaches combined with behavioral and communication-based interventions (Binik & Meana, 2009). In particular, Dr. Helen Singer Kaplan's approach in the 1970s integrated medical and psychological approaches with sex therapy (Southern & Cade, 2011). A new category of sexual dysfunctions first appeared in the DSMIII in 1980 (Binik & Meana, 2009). Sexuality moved further into the mainstream of social dialogue in the United States in the 1980s with the publication of several high-profile sexual self-help books and numerous TV personalities (e.g., Dr. Ruth) emerging on different media platforms (Binik & Meana, 2009; Southern & Cade, 2011).

Moving further into the 1980s and 1990s, the field of sex therapy experienced a shift toward medical approaches to treating sexual dysfunction, especially with a series of highly publicized medications designed to treat erectile dysfunction (Goodwach, 2005a; Tiefer, 2006). By and large, conceptualizations of sexual dysfunctions were grounded in heterosexual sexuality (Marshall, 2002). The focus on medical aspects of sexuality has received some pushback from sex therapists and feminist scholars (Tiefer, 2001). In particular, advocates have raised concerns that the pharmaceutical industry will do to female sexuality what they perceived occurred to male sexuality, which is reducing it to problems that are solvable simply by popping a pill (Tiefer, 2001). Further, advocates argue that the full scope of human sexuality and eroticism is difficult to capture in empirical medical approaches to research (Tiefer, 2001).

In response to the increasing medicalization of sexual problems, a feminist working group convened to develop the New View Campaign to present an alternative framework for understanding women's sexual concerns (Nicholls, 2008; Southern & Cade, 2011). Rather than adopting a view of sexual problems that is based in Masters and Johnson's conceptualization of the sexual response cycle, the New View focused on the multiple contexts that influence women's sexuality, including their physiology, psychology, and social relationships (Nicholls, 2008). The fundamental tenet of the New View is that women's sexual functioning can

best be understood within their relational context. The New View suggests that women's sexual problems generally fall into the following four categories, with additional subcategories falling within each broader category: (a) sexual problems due to sociocultural, political, or economic factors (e.g., lack of sex education or health care and problematic social norms); (b) sexual problems relating to partner or relationship (e.g., abuse, different levels of desire, and communication problems); (c) sexual problems due to psychological problems (e.g., sexual aversion and fear); and (d) sexual problems due to medical factors (e.g., pregnancy, medication side effects, and medical conditions) (Southern & Cade, 2011). Nicholls conducted a qualitative study to determine the extent to which the New View aligned with women's lived experiences of their sexuality. Approximately 70% of the women's sexual concerns corresponded with the subcategories of the broader categories outlined in the New View framework, and Nicholls suggested that the other concerns were aligned with the framework with some modifications.

More recently, the sex therapy field has shifted to a more comprehensive, systemic approach to understanding and treating sexual concerns (Goodwach, 2005a). This has included a greater acceptance of varying sexual orientations, an increased treatment focus on family-of-origin issues, and more emphasis on sexual education for clients (Goodwach, 2005a). In addition, Althof (2010) noted that four major, recent advances in the sex therapy field include advances in combined medical and psychotherapeutic approaches, the use of mindfulness-based approaches, therapy that integrates the use of the Internet, and new approaches to understanding and treating female genital pain disorders. Another important development in more recent decades was the proliferation of Internet use among the general population, which provided both positive advances—such as greater availability of sexual health information—and potential pitfalls—such as easier access to compulsive sexual behaviors (Southern & Cade, 2011).

Clients today still may seek help for sexual concerns and desire behavioral and/or medical solutions (Goodwach, 2005b; Marshall, 2002). Indeed, the medical aspects of sexual treatment have outpaced new psychotherapy advances in the new millennium (Althof, 2010). Some sex therapists view the focus on medical advancements as a detriment to the field because of the preferred emphasis on medical treatments as compared to psychotherapeutic ones (Binik & Meana, 2009). However, psychotherapy can be integrated into medical treatment (Binik & Meana, 2009) and may even offer benefits and growth for the sex therapy field (Binik & Meana, 2009). Pukall and Reissing (2007) suggested that advancements in medicine related to human sexuality will not harm, but rather help, the non-medical professional approaches to sexuality. In particular, they suggested that medical advancements offer new opportunities for sex therapists to train medical professionals about

sexuality and relationships. Medical advances also raise the public profile of the topic of sexuality, such that members of the general population may become more inclined to seek all forms of treatment for their sexual concerns.

Within the past 20 years, the field of sex therapy and counseling has been criticized for failing to advance and innovate (Althof, 2010; Binik & Meana, 2009). However, the research base surrounding the treatment of sexual problems has continued to grow and encompass more rigorous methods (Althof, 2010). Within the relatively short history of this area of practice, there have been numerous and significant changes in the practices and assumptions within the field. At the same time, there has been a growing emphasis on the professionalism of the field, as evidenced by the current availability of the professional credentials discussed in the next section.

Credentialing and Professional Identity Issues

Professional organizations and credentialing help to ensure that a profession maintains high standards and protects client welfare (Guldner, 1995). In addition, credentialing requires that professionals meet minimum training and experiential requirements specific to sexuality, and professionals without credentials have no such guaranteed minimal requirements (Kleinplatz, 2009). Although there are credentials available for sexuality counselors and sex therapists (Binik & Meana, 2009), these areas of practice generally are not regulated by state licensure bodies, and therefore, there is less oversight of practice in these areas than in general mental health professional licensure (Binik & Meana, 2009).

Distinguishing Between Sexuality Counseling and Sex Therapy

Before describing the main credentialing options available, it is important to begin with definitions that can help to clarify the difference between *sexuality counseling* and *sex therapy*. The American Association of Sexuality Educators, Counselors, and Therapists (AASECT) is the primary credentialing organization in the United States. AASECT (2013) offers the following definitions of sexuality counselors as compared to sex therapists:

> Sexuality counselors . . . assist the client to realistically resolve concerns through the introduction of problem solving techniques of communication as well as providing accurate information and relevant suggestions of specific exercises and techniques in sexual expression. Sexuality counseling is generally short term and client centered, focusing on the immediate concern or problem. (para. 2)

Sex therapists are licensed mental health professionals, trained to provide in-depth psychotherapy, who have specialized in treating clients with sexual issues and concerns. . . . Sex therapists work with simple sexual concerns also, but in addition, where appropriate, are prepared to provide comprehensive and intensive psychotherapy over an extended period of time in more complex cases. (para. 3)

Therefore, according to AASECT (2013), the main distinctions between sexuality counselors and sex therapists are the degrees of the intensity of the treatment and the complexity of the cases. Southern and Cade (2011) stated that sexuality counseling incorporates a focus on developmental influences on individual and relational sexual functioning, and it also integrates general counseling theories, current research-based approaches, collaborations with medical professionals, and postmodern thinking. Sex therapy is considered to be much more specialized than sexuality counseling, as reflected in Althof's (2010) statement that sex therapy is "a specialized form of psychotherapy that draws upon an array of technical interventions known to effectively treat male and female sexual dysfunctions" (p. 6). Later in this chapter, we will discuss the PLISSIT model, which is a useful tool for helping practitioners determine which cases require the more intensive therapy provided by sex therapists (American Association of Sexuality Educators, Counselors, and Therapists, 2013).

Is Sexuality a True Specialty Area?

The specialized credentialing of sexuality counselors and sex therapists has not been without controversy, and there has been some professional dialogue regarding whether sex therapy is justifiably considered a unique specialization. For example, Binik and Meana (2009) suggested that sex therapy lacks many of the basic foundations needed for a psychotherapy practice to be considered a unique specialty, including a strong underlying theoretical basis, a distinct approach to clinical practice, and a strong empirical basis to show the effectiveness of treatment. Binik and Meana argue that the view of sex therapy as a distinct specialty has had the effect of marginalizing sexual treatment within the broader field of psychotherapy. As a result, many counselors view sexuality-focused treatment as falling outside the scope of their practice (Binik & Meana, 2009).

In response to Binik and Meana (2009), Kleinplatz (2009) wrote that credentialing in the area of sex therapy and sexuality counseling serves the primary and important function of protecting clients. In particular, due to the general lack of training in sexuality among most mental health professionals, in combination with the proliferation of inaccurate and biased information that exists in society, there is a high potential for harm when clients seek treatment related to sexuality from inadequately trained professionals (Kleinplatz, 2009). Kleinplatz cited anecdotal evidence that credentialed therapists often work with clients who have been harmed by other, inadequately prepared professionals when they practiced outside of the bounds of

their competence. Kleinplatz goes on to suggest that until all mental health and other healthcare professionals receive adequate training in sexuality as part of their professional preparation, specialized credentials are needed. Tiefer (2009) also responded to Binik and Meana (2009) and suggested that a specialization related to sexuality is necessary because sexuality is an inherently and extensively complicated issue that faces unique contexts—especially related to the social, political, and relational contexts—as compared to other areas of mental health practice.

Despite the dialogue regarding whether sexuality counseling and sex therapy are justified as being considered unique specialization areas, both professionals and the general public now view sex therapy as a specialized discipline (Binik & Meana, 2009). The availability of professional training programs for professionals interested in working as sex therapists or sexologists, as well as specialized professional journals (Binik & Meana, 2009), add to the general view that these areas require specialized training and educational experiences.

Credentialing Options

AASECT (2013) offers certification as a certified sexuality counselor and as a certified sex therapist, in addition to their certified sexuality educator credential for those who do teaching and training about sex and sexuality. Both of the sexuality counselor and sex therapist certifications require a combination of professional requirements (e.g., membership in AASECT and adherence to the AASECT Code of Ethics), educational requirements, direct practice (i.e., clinical work) under appropriate supervision, and training experiences addressing personal attitudes and values related to sexuality (American Association of Sexuality Educators, Counselors, and Therapists, 2013). Mental health professionals who hold at least a master's degree and are licensed in their states are not eligible for the certified sexuality counselor credential, as they are only eligible for credentialing as a certified sex therapist once they meet the requirements (American Association of Sexuality Educators, Counselors, and Therapists, 2013). Readers interested in these credentialing options are encouraged to consult the AASECT website (www.aasect.org) for the most current information regarding credentialing requirements.

Relevant Professional Organizations

Counselors interested in gaining additional information and professional networking opportunities may wish to become involved with AASECT and/or other professional associations related to sexuality. Beyond AASECT, which holds an annual conference and offers other such benefits as a referral service, list-serv, and advocacy, two other relevant organizations are the Society for Sex Therapy and Research (SSTAR; http://www.sstarnet.org/) and the Sexuality Information and Education Council of the United States (SEICUS; www.seicus.org). All of these

organizations are very interdisciplinary (Binik & Meana, 2009) and provide potentially valuable resources for sexuality counseling.

PROFESSIONAL COMPETENCE IN SEXUALITY COUNSELING

Ethically, professionals must always practice within the bounds of their professional competence. Therefore, professionals must understand their own level of competence to address sexuality-related issues in their work. Whether or not they seek a specialized credential in this area, all counselors should be equipped with a basic understanding of sexuality issues, as well as where they can refer clients for issues that extend beyond the scope of their own competence. Again, clients in any clinical setting may experience sexuality-related problems or other concerns that impact their sexual functioning. However, existing research suggests that most mental health professionals lack the basic competence to address sexuality issues in counseling (Harris & Hays, 2008). This is problematic for a number of reasons because when counselors fail to address sexuality-related issues with their clients, issues that are important to clients may be ignored and clients remain ill-equipped to process the misinformation about sexuality that they receive from others and social messaging (Harris & Hays, 2008).

Training related to sexuality is sorely lacking in many mental health, professional training programs. For example, Miller and Byers (2010) surveyed 162 practicing clinical and counseling psychologists in the United States and Canada. They found that although less than one-third (31%) of the psychologists they surveyed had taken a graduate-level course in sexuality and less than 70% of them had received any other form of observational learning related to sexuality during their graduate training, most participants had provided psychotherapy to clients whose concerns related to sexuality. Training in certain areas, such as masturbation, STIs, and working with sex offenders, was especially limited. Many of the participants in Miller and Byers had sought out other forms of education (e.g., reading books and attending workshops). Of course, the quality and content of these informal resources can vary widely.

We cannot understate the importance of counselors seeking out training and experience to foster their competence in the area of sexuality counseling. Two surveys of mental health professionals underscore the importance of knowledge in this area. First, Juergens, Smedema, and Berven (2009) surveyed 116 students in master's degree programs for rehabilitation counseling in the United States. They found that students who had greater levels of knowledge about sexuality, as well as more comfort with sexuality, were more willing to discuss sexuality-related issues with their clients. Second, in a survey of clinical members of the American Association for Marriage and Family Therapy, Harris and Hays (2008) found that therapists

who had specific training and who had received supervision related to sexuality counseling issues were most likely to feel comfortable raising the topic of sexuality with their clients. In addition, therapists who were more comfortable themselves with the subject of sexuality were, perhaps not surprisingly, more comfortable raising the topic with their clients. To assist readers in determining their current level of competence for sexuality counseling and in identifying areas for further growth, we provide the following checklist of the core components of competence to address sexuality in counseling (Kazukauskas & Lam, 2009; Southern & Cade, 2011).

Exercise 1.1

WHAT IS YOUR CURRENT LEVEL OF COMPETENCE IN SEXUALITY COUNSELING?

Consider the following questions that reflect different aspects of competence in sexuality counseling. Circle "Yes" or "No" in response to each question. The questions for which you answered "No" are indicators of areas in which you may benefit from seeing additional training, experience, and/or information about local and national resources.

1. Are you comfortable talking about sexuality with clients? Yes/No

2. Do you understand the impact that common sexual health problems (e.g., STIs, infertility, sexual dysfunctions, relational conflict about sexual intimacy, and high-risk sexual behaviors) can have on clients? Yes/No

3. Are you knowledgeable about appropriate assessment strategies to assess the sexual health problems described in question 2? Yes/No

4. Are you knowledgeable about appropriate treatment strategies to use in counseling to address the sexual health problems described in question 2? Yes/No

5. Do you understand the basics of human anatomy and physiology related to sex and sexuality, such that you could describe these to clients? Yes/No

6. Do you have the training and experience to be competent to address related client concerns, such as body image and relationship issues? Yes/No

7. Are you knowledgeable of and connected to referral sources for clients whose sexuality-related concerns are beyond your competence? Yes/No

8. When addressing sexuality issues in counseling, are you able to maintain appropriate boundaries and address boundary crossings, such as a client expressing romantic interest in you? Yes/No

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Readers likely vary in their levels of competence in each of the items included on the checklist above (Southern & Cade, 2011). To help counselors further determine those sexuality-related issues they are competent to address and those for which they should refer clients to specialized treatment, Juergens, Smedema, and Berven (2009) and Southern and Cade (2011) provided an overview of Annon's PLISSIT Model. This model's name stands for Permission – Limited Information – Specific Suggestions – Intensive Therapy. This model provides a framework for helping counselors decide if and when to refer clients for help that reaches beyond the scope of their competence. At the first level of Permission, clients receive the opportunity and support to discuss their sexuality concerns. Second, the Limited Information level involves counselors offering clients accurate sex information and the chance to explore the social messages surrounding clients' concerns. The third level of Specific Suggestions involves specific interventions that are designed to meet the clients' needs, and these may integrate interventions focusing on physiology, mental health, and/or relationships. At the final level of Intensive Therapy, clients receive in-depth treatment to address the full complexity of their concerns. Counselors must consider which of these levels their training and experience have adequately equipped them to provide to clients (Southern & Cade, 2011).

The question of when counselors should refer clients for specialized treatment (e.g., to a certified sex therapist) is a complicated one. Counselors must consider carefully whether they are referring out of personal discomfort rather than based on what is in the best interest of the client (Binik & Meana, 2009). Clients may feel that their concerns are being dismissed by the original therapist if they are immediately referred for specialized sex therapy treatment (Binik & Meana, 2009). When a counselor refers a client to a specialized sex therapist for specific treatment of a sexual dysfunction, she or he runs the risk that the client's sexual dysfunction may be treated outside of the broader context surrounding the client's sexual concerns, including relational, other psychological, and broader social context issues (Binik & Meana, 2009). When a client's sexual concerns fall clearly outside of the counselor's level of professional competence, a referral for specialized sex therapy may indeed be warranted. However, these referrals must be handled with care to ensure that the client's needs are considered during the transfer process.

There is a critical need for more training in sexuality for counselors (Harris & Hays, 2008). Until this is widely done, however, many counselors will be left to their own devices to seek out the knowledge, skills, and personal comfort to address these issues with their clients. Counselors should be up front with their clients if they are venturing into an area around which the counselor has limited competence and/or training (Corley & Schneider, 2002). We also suggest clinical supervision in areas where counselors are developing new areas of competence.

Competence and Personal Values: The Importance of Self-Reflection

In the realm of sexuality, counselors must be careful to avoid confusing personal values that conflict with clients' choices for a lack of competence. Counselors are ethically bound to provide services without discriminating against clients based on their ethnic backgrounds, nationality, gender, sexual orientation, and other personal characteristics (e.g., American Counseling Association, 2014). This can certainly present challenges to counselors if they hold personal beliefs that conflict with clients' sexual orientations, culturally derived sexual norms, or other sexual practices. In light of a string of recent court cases, the issue as to whether religious counselors may refuse to work with homosexual clients on the grounds of their religious beliefs has recently received a good deal of professional attention (Priest & Wickel, 2011). These cases have shown that when someone enters a training program and profession that ascribes to a Code of Ethics that contains such a nondiscrimination policy, they are required to be able to provide counseling services to clients without discrimination, regardless of their personal beliefs (Rudow, 2012; 2013).

Simply referring clients whose sexual orientations or practices are uncomfortable to counselors has a great potential for harming clients (Priest & Wickel, 2011). Certain client populations, such as lesbian, gay, bisexual, and transgender (LGBT) clients, have historically felt marginalized from psychotherapy, and so it may be valuable for counselors to make extra efforts to make their treatment settings welcoming and responsive to these clients' needs (Safren, 2005; Sobocinski, 1990). Beyond sexual orientation, counselors should consider other sexual concerns or practices that may lead them to have potentially harmful reactions to clients. For example, consider a counselor who believes that sexual intercourse should occur only in the context of a committed, heterosexual marriage. How might this counselor react when a client shares experiences of swinging or engaging in a ménage a trois? This counselor may have an internal reaction (e.g., anxiety, judgmental thoughts, or disgust), as well as a nonverbal response, such as raised eyebrows, a facial expression of shock, or a change in tone of speech (e.g., talking quickly or with a shaky voice). Managing internal reactions is part of an ongoing process of self-reflection for counselors, and if managed effectively, these reactions can be prevented from negatively impacting the counseling relationship. However, the likely impacts of negative non-verbal responses include clients feeling judged or condemned, losing trust in the counselor, and choosing to not disclose additional personal information. Therefore, counselors must be aware of possible biases that they bring to the counseling relationship (Goodwach, 2005b; Priest & Wickel, 2011). Through personal reflection, clinical supervision, and consultation, counselors should examine their biases and the extent to which these may impact their competence in treating certain client populations (Goodwach, 2005b; Sobocinski, 1990).

The Ability to Talk Professionally and Comfortably About Sexuality as a Counselor

Sex and sexuality are often very difficult topics to discuss, whether personally or in a professional context. Binik and Meana (2009) suggested that although many mental health professionals lack comfort in talking about sexuality-related issues with clients, sexuality is a significant and natural part of life that all counselors must strive to develop comfort and competence to address in their work. Binik and Meana even said, "If sex, the very activity that perpetuates human life, is a source of paralyzing anxiety for a would-be mental health practitioner, then something is wrong with our professional training" (p. 1023).

A more valuable question to ask than, "Are you comfortable talking about sexuality with your clients?" is "Which aspects of sexuality are you more and less comfortable discussing?" Given all of the conflicting societal messages and lack of education on sexuality, it is likely that every single person has certain sexuality-related topics that they would be at least somewhat anxious to talk about with others. Some counselors may feel wholly uncomfortable with the topic, while others may experience discomfort in just a few specific topic areas. Nonetheless, existing research suggests that feeling comfortable talking about sexuality may be even more important than knowledge in counselors' ability to raise the issue of sexuality with their clients (Harris & Hays, 2008).

Counselors therefore should strive to increase their comfort in talking about sexuality in a professional context. Several activities can help to promote this comfort. First, counselors can practice engaging in these discussions during training exercises, clinical supervision, and professional consultation. Second, counselors can develop an extensive vocabulary to use when discussing sexuality issues. As will be discussed later in this book, it is important for counselors to use language that is in line with clients' worldviews. Overly clinical and technical language can decrease the emotional aspects of clients' experiences, whereas overly informal language may be interpreted as crude or offensive by clients. Third, when addressing sexuality concerns with clients, counselors must strike a balance between the professional boundaries in place and the personal impact of this work (Nijs, 2006). Counselors of course cannot deny their humanity and are likely to be impacted personally by their work related to sexuality, especially when working with clients impacted by sexual trauma (Nijs, 2006). Therefore, to continue to develop increasing comfort in addressing sexuality in counseling, counselors should engage in self-care when working with clients on sexuality-related issues (Nijs, 2006). Finally, counselors can engage in ongoing reflection to examine their personal barriers to becoming comfortable discussing sexuality, as well as strategies to overcome these barriers. To help counselors start with this final activity, we provide sample reflection questions in Exercise 1.2.

Exercise 1.2

GUIDED REFLECTION EXERCISE: BARRIERS TO PERSONAL COMFORT IN TALKING ABOUT SEXUALITY

Take time to consider your reactions to the following questions. You can write in a journal about your responses or discuss your responses with a trusted colleague or supervisor.

1. Growing up, how comfortable was your family in talking about sex and sexuality?

2. What messages did you receive when talking about sexuality when you were a child?

3. Thinking back to the earliest questions about sexuality that you asked adults during your childhood, what responses did you get to these questions?

4. With which types of clients do you believe you would be most and least comfortable talking about sexuality? What factors make you more or less comfortable with each population?

5. Which sexual practices might clients discuss that would be most shocking to you? How do you think you would respond if a client talked about his or her experiences with these practices?

6. Imagine if a client asked you to give him or her specific advice on sexual technique (e.g., how to make a partner orgasm or how to masturbate). What would your response be?

7. Think through the clinical, informal, and slang terms you know to describe sex and sexual parts of males' and females' bodies. What reactions do you have to these words? Now imagine saying those words to a client or supervisor. What emotional reactions might you have to saying those words?

ETHICAL CONSIDERATIONS FOR SEXUALITY COUNSELING

Sexuality counseling presents counselors with unique ethical considerations that reflect the sensitive and personal nature of the subject of sexuality. In this section, we draw upon two primary ethical codes, that of the American Counseling Association (ACA; American Counseling Association, 2014) and the American Association of Sexuality Educators, Counselors, and Therapists (AASECT; American

Association of Sexuality Educators, Counselors, and Therapists, 2004). Mental health professionals from other disciplines must be sure that they are following the ethical guidelines of their professional associations, as well as all relevant legal regulations. In addition to the ethics of the competence issues already reviewed above, the ethical issues reviewed in this section are as follows: the ethics of sexual relationships and client vulnerability, client confidentiality and secrets, so-called reparative therapies for clients with a same-sex orientation, and sexual attractions or relationships within client-counselor and counselor-supervisor relationships. Additional ethical considerations are discussed throughout this book in the relevant chapters. Counselors are advised to seek additional training through continuing education programs to maintain an ongoing focus on addressing these ethical concerns throughout their careers (Hoffman, 1995).

The Ethics of Sexual Relationships and Client Vulnerability

Sexual relationships bring inherent ethical dimensions. Darling and Mabe (1989) suggested that there are four main principles for determining whether sexual relationships are ethical. The first principle is *noncoercion*, in that people should have full ability to choose for themselves whether, when, and how they wish to engage in sexual activities. Second, the principle of *nondeceit* holds that people should have full information available to them when deciding whether to engage in sexual activities. The third principle suggests that *people should not treat others solely as means to an end*, namely that they should not be used merely for another person's personal sexual gratification. The final principle of *respect for beliefs* holds that people should respect their partners' beliefs about sex and not set out to change those beliefs. Counselors must consider all of these dimensions as they help their clients navigate the sexuality concerns they bring to counseling.

Because each of these dimensions is extremely complex and open to different interpretations, sexuality is an inherently sensitive aspect of people's lives and relationships. This sensitivity can contribute to a unique level of vulnerability for clients seeking counseling related to their sexuality. The AASECT (2004) Code of Ethics even states, "The member shall bear a heavy social responsibility because society deems the services as representing specialized expertise and because the consumers using the services are vulnerable" (para. 2). Sexuality is perhaps one of the most private areas of people's lives, and for a variety of reasons, many people carry a lot of shame and discomfort about their sexual practices, histories, and experiences. To begin to understand the nature of the vulnerability of clients in counseling discussing their sexual concerns, we encourage readers to pause reading in order to do the following guided reflection exercise on client vulnerability.

Exercise 1.3

GUIDED REFLECTION EXERCISE: CLIENT VULNERABILITY IN SEXUALITY COUNSELING

First, think about some aspect of your own sexuality—such as a past experience, a preference you have for types of sexual activity, or some physical characteristic—that may lead you to feel uncomfortable, upset, or embarrassed.

Second, think through some of the reasons that this issue brings up an emotional response for you. Perhaps you've been teased about this issue by someone else. Maybe you fear what people would think about you if they knew that you did this or think this way. It could be that you view this issue as going against your or your community's religious or cultural values.

Third, consider how you would feel speaking about this issue with a professional counselor. Ask yourself, "If I were to tell my counselor about this issue, what would I be feeling, and what would I be looking for in how my counselor reacts to me?"

Counselors must be proactive in creating a counseling environment in which clients can feel safe and supported in discussing some of their most personal thoughts, feelings, and experiences. In addition to working to build a strong rapport with clients, three fundamental ethical principles can guide counselors in creating this supportive environment. First, it is important for counselors to maintain professional boundaries at all times when engaging in sexuality counseling (American Association of Sexuality Educators, Counselors, and Therapists, 2004; Principle 3.4). A clear professional boundary can help assure the client that the counselor is competent and prepared to address the client's sexuality concerns in an ethical and professional manner. Second, sexuality counselors must avoid imposing their values on their clients (American Counseling Association, 2014, A.4.b). Sex is an extremely value-laden issue. Because counselors have a powerful position with regard to their level of influence on their clients, they must be extremely careful to ensure that they do not use this privileged position to sway clients toward their own personal value systems. Third, counselors should respect clients' autonomy for their own lives and decisions. The ACA (2014) Code of Ethics states that counselors' primary ethical responsibility is "to respect the dignity and to promote the welfare of clients" (A.1.a). Therefore, on the one hand, clients in sexuality counseling can be considered vulnerable because of the sensitive nature of the topic of sexuality. However, counselors must bear in mind that their role is to help their clients make

decisions and behavioral changes that support their own life goals, even if the counselor has reason to believe that behavior may have negative consequences. Exceptions to confidentiality in issues such as this are discussed below.

Client Confidentiality and Secrets

Client confidentiality issues are especially relevant for sexuality counseling, given the sensitive nature of the subject. When there are possible legal implications of the clinical work (e.g., when working with sex offenders; Aubrey & Dougher, 1990; Priest & Wilcox, 1988), counselors should be especially mindful of client confidentiality issues. As in all counseling, the limitations to confidentiality should be discussed clearly with clients at the outset of therapy (Priest & Wickel, 2011). As discussed above, counselors must respect clients' autonomy. However, there may be cases in which counselors view clients' decisions as having potentially harmful consequences for themselves or for others. The decision whether to break confidentiality in such cases must be made carefully and through consultation with other professionals (American Counseling Association, 2014), including possibly seeking legal advice. When there is a risk of severe harm, as in a threat of suicide or homicide, breaking confidentiality is ethically justifiable (American Association for Sexuality Educators, Counselors, and Therapists, 2004; American Counseling Association, 2014). However, the ethical response to some sexual issues is less clear. For example, a client may disclose that he intends to coerce a partner into sexual activity. Disclosing this information to the partner (especially when the partner is not a client in conjoint treatment) is a more ambiguous issue. The AASECT (2004) Code of Ethics states that confidential information may be disclosed "when there is clear and imminent danger of bodily harm or to the life or safety of the consumer or another person" (Principle 3.D.2). This client's counselor will need to gather additional information and consult with colleagues to determine if a disclosure is warranted. Sexually transmitted diseases are another related concern, and the ACA (2014) Code of Ethics says the following:

> When clients disclose that they have a disease commonly known to be both communicable and life threatening, counselors *may* [emphasis added] be justified in disclosing information to identifiable third parties, if they are known to be at demonstrable and high risk of contracting the disease. (B.2.b)

The use of the word "may" in the standard above indicates that there is substantial room for interpretation in these cases. Counselors in this situation must weigh the following factors: the severity of the diagnosis and disease, the ability to identify the third party at risk of contracting the disease, and all relevant laws in their jurisdiction.

Another ethical consideration that may arise when working with clients around sexuality issues is whether and how counselors should keep secrets for clients in conjoint couple treatment, as Corley and Schneider (2002) discussed. According to these authors, secrets may be especially prominent when working with clients in which one partner has a sex addiction. In general, keeping secrets for clients can be difficult for therapists and damaging to the therapeutic relationship. Keeping a secret may be warranted in some situations, however, such as when disclosing the secret could lead to physical violence. When appropriate, therapists can work toward disclosure of the secret by the client during a session to facilitate appropriate processing of the disclosure and a supportive context for the revelation of the previously undisclosed information (Corley & Schneider, 2002).

Reparative Therapies

When counselors have the opportunity to work with clients exploring their sexual orientation, additional ethical considerations may arise. One particularly controversial area is the topic of reparative therapies (also referred to as *conversion therapies*) that aim to assist clients in getting rid of their same-sex sexual attractions (Drescher, 2001; Forstein, 2001; Morrow & Beckstead, 2004; Safren, 2005; Schroeder & Shidlo, 2001; Throckmorton, 1998; Yarhouse & Throckmorton, 2002). Proponents for the availability of reparative therapy suggest that clients should have the right to work toward changing their sexual orientations, especially if their career situations and/or religious beliefs penalize them for same-sex attractions (Drescher, 2001; Morrow & Beckstead, 2004; Throckmorton, 1998; Yarhouse & Throckmorton, 2002). However, these approaches are reflective of social stigmatization of homosexuality and can have damaging and blaming effects for clients (Drescher, 2001). Further, historically many of the clients who have entered reparative therapies have not done so under full free will, but rather, they were forced or coerced into treatment by their family members or religious organizations (Drescher, 2002). In addition, reparative therapies are unproven and are largely based on political and religious dialogue rather than on sound scientific evidence (Forstein, 2001). For these reasons, reparative therapies violate many basic principles of counseling ethics, including "competence, integrity, respect for people's rights and dignity, and social responsibility" (Morrow & Beckstead, 2004, p. 648). Thus, reparative therapies have been denounced by most major mental health professional organizations (Just the Facts Coalition, 2008).

In contrast to reparative therapies, "identity therapists" are those who believe that sexual orientation is but one aspect of a person's human development and believe that counselors should not attempt to change clients' sexual orientations (Drescher, 2002). When working with clients questioning their sexual orientations,

it is important for counselors to avoid pushing their clients toward one sexual orientation or another (Drescher, 2002). During this process, counselors may feel compelled to disclose their personal sexual orientations with their clients (Drescher, 2002), but this and all forms of self-disclosure should be done carefully and with ultimate respect for the clients' welfare.

Sexual Attractions or Relationships With Clients or Supervisees

An ethical issue on which there is clear consensus is that sexual relationships with clients are harmful to clients and are unethical (Avery & Gressard, 2000; Larrabee & Miller, 1993; Plaut, 2008; Seto, 1995). Sexual misconduct is one of the more frequent ethical violations reported to state professional credentialing agencies (Avery & Gressard, 2000; Hoffman, 1995). Sexual relationships with clients are a violation of the trust that clients place in their counselors (Cummings & Sobel, 1985). These relationships can have many negative impacts on clients, including shame, anger, being afraid to seek additional counseling in the future, depression, confusion, and fear (Schoener, Milgrom, & Gonsiorek, 1984; Seto, 1995). Research suggests that sexual misconduct with clients is more likely among male therapists but does not differ based on professional discipline (Seto, 1995). Sexual relationships may arise if either or both the counselor and/or client are especially vulnerable, such as after a divorce (Edelwich & Brodsky, 1984). Counselors who engage in sexual relationships with their clients often rationalize this behavior (Edelwich & Brodsky, 1984), such as by viewing the counseling relationship as complete and separate or by claiming that their connection transcends professional boundaries. Counselor-client sexual relationships can develop through a number of pathways, including the client taking on a role of wanting to help the counselor and the proverbial case of 'one thing leading to another' (Hoffman, 1995). Clients who have previously been exploited by a former counselor may require additional sensitivity to ensure that the client has the opportunity to work through the negative impacts of those experiences (Schoener, Milgrom, & Gonsiorek, 1984).

Although sexual relationships with current clients are viewed as clearly unethical, some related issues, such as sexual relationships with former clients or with supervisees, are less clear (Avery & Gressard, 2000; Hoffman, 1995; Larrabee & Miller, 1993). Some states do prescribe time limits on how long after the counseling relationship terminates counselors and former clients are not allowed to engage in a sexual relationship, although some states have no such limits (Avery & Gressard, 2000). The range of timelines varies widely. Avery and Gressard (2000) reported ranges from six months to three years, with some states providing for extensions on the timeline if the client remains vulnerable beyond the set timeline. The question of how long after treatment ends a client remains vulnerable to the power differential inherent in the counselor-client relationship remains uncertain,

although there is growing recognition that some forms of counseling creates a greater sense of vulnerability than others, such as the contrast between brief career counseling and intensive, long-term psychotherapy (Hoffman, 1995).

Some state statutes also prohibit counselors from engaging in sexual relationships with supervisees, and sexual harassment regulations also may come into play in these situations (Avery & Gressard, 2000). A counseling supervisor holds power over his or her supervisees, and supervisors can use sexual relationships to coerce and manipulate their supervisees (Larrabee & Miller, 1993; Plaut, 2008). Sexual relationships between supervisors and supervisees also likely cloud the supervisor's ability to effectively serve in a gatekeeping role for the profession (Larrabee & Miller, 1993). Counselors should consult their local jurisdiction's regulations when considering sexual relationships with former clients and/or current or former supervisors or supervisees to ensure that they are not violating any legal statutes. If readers are not currently familiar with regulations in their local jurisdiction regarding these matters, we suggest they pause reading to seek out relevant regulations before proceeding to read further in this chapter.

Heiden (1993) advocated for increased efforts to implement counselors-in-training strategies for preventing counselor-client sexual relationships. The following examples of Heiden's recommendations offer valuable guidance to both trainees and practicing counselors. First, counselors should monitor whether they are providing differential treatment to clients and whether that reflects that they are attempting to meet their own needs for intimacy with certain clients. Second, counselors should gain a greater understanding of the dangers involved in counselor-client sexual relationships, and these dangers should be kept at the forefront of counselors' minds when such possibilities arise. Third, counselors should take preventive steps to ensure that they do not find themselves in situations in which they would be tempted to engage in sexual activities with clients. These steps may include discussing the situation with others, seeking professional therapy oneself, and identifying and addressing issues of possible transference and countertransference early. Training programs also can promote ethical behavior in this regard by modeling clear professional boundaries and adequate training on sexuality-related issues that impact the counseling process (Hoffman, 1995; Plaut, 2008).

Although sexual relationships between counselors and clients are clearly unethical, sexual attractions certainly may arise between the counselor and client, whether one-sided or mutual (Edelwich & Brodsky, 1984; Hoffman, 1995; Rodgers, 2011). Such attractions may be especially likely to develop when sexuality-related topics are discussed in session. Clients may be especially likely to experience these feelings if they are being treated for sex addictions (Griffin-Shelley, 2009). These attractions may reflect natural human attraction processes and/or transference and countertransference (Edelwich & Brodsky, 1984). Edelwich and Brodsky (1984) suggested that clients who are attracted to their counselors may engage in various

behaviors that push the limits of the professional boundary that defines their relationship with their counselor. These behaviors may include enhancing their appearance for sessions, asking the counselor intimate questions about the details of their lives, and making frequent unscheduled contacts, both in and out of the office, with the counselor. Clients also may seduce their counselors to avoid working on their presenting concerns (Edelwich & Brodsky, 1984). When a client discloses attraction toward a counselor or the counselor suspects that the attraction has developed, the counselor must address this issue in a therapeutic and ethical manner.

Countertransference reflects counselors' reactions and feelings that they develop toward their clients (Griffin-Shelley, 2009). When countertransferential reactions arise, counselors should monitor these carefully and examine the impact they have on the therapeutic relationship (Griffin-Shelley, 2009; Rodgers, 2011). When counselors do not manage these reactions effectively, the result can be a negative impact on the clients (Griffin-Shelley, 2009). If therapists experience sexual feelings toward their clients, they must consider carefully whether to disclose these to the clients (Fisher, 2004). Processing these feelings with a clinical supervisor, colleagues, or one's own therapist can provide valuable insights as to the reasons for these attractions (Fisher, 2004; Rodgers, 2011). These feelings can then be normalized, and in and of themselves, they do not constitute sexual misconduct (Fisher, 2004; Hoffman, 1995). However, many therapists feel ashamed when these attraction feelings arise (Rodgers, 2011). For a therapist to disclose these feelings to a client is more likely to be harmful to the client than it is to offer them any therapeutic benefits, and it can also expose the therapist to a potential slippery slope toward sexual misconduct (Fisher, 2004).

INTERDISCIPLINARY COLLABORATIONS FOR SEXUALITY COUNSELING

Sexuality is an interdisciplinary topic that can be addressed on many different levels. Counselors working with clients on sexuality-related concerns should consider other community resources that may help clients make further progress toward their treatment goals. A first step for virtually any possible sexual dysfunction is for clients to have a physical examination by a qualified health care professional to determine if physiological causes are contributing to clients' concerns (Goodwach, 2005b). Medical interventions—such as medications—may be useful for clients when there is a physiological basis for their concerns. There is growing recognition of the importance of integrated mental health and medical treatment for sexual problems, often referred to as combination therapy (Althof, 2010). The integration of both approaches can help to capitalize on the benefits that clients may achieve through each approach and help clients achieve their treatment goals more quickly and efficiently (Althof, 2010).

Further, combination therapies can help to ensure that the medical, psychological, and relational implications of clients' sexual concerns are all addressed adequately (Althof, 2010). The diverse group of medical professionals with whom sexuality counselors may work includes the following: urologists, gynecologists, endocrinologists, family practice physicians, internists, cardiologists, neurologists, nurse practitioners, physician assistants, and physical therapists (Althof, 2010).

Beyond collaborations with medical professionals, counselors can assist their clients in accessing other potentially helpful resources, and counselors can work with professionals involved with these resources to promote clients' treatment progress. For example, clients may benefit from resources that provide information about sexual health and any specific concerns the client is facing. Therefore, counselors should become familiar with sources of credible sexual health information in their communities, as well as other sources available online and in print media (e.g., books, magazines). Counselors also can provide clients with information about support groups in their communities for people facing similar issues, such as infertility and sex addiction. Many communities also offer centers or groups for the LGBT population, as well as groups for family members of these people (e.g., PFLAG: Parents, Families, Friends, and Allies United with LGBT People). Some clients may need assistance with finding legal advice, such as if they have experienced a sexual assault. Other community-based programs that may be relevant for some clients include support programs for teenage parents, agencies that provide free or reduced-cost contraception, sex trafficking recovery organizations, couple relationship-education workshops, parenting education programs, and culture-specific organizations. We encourage counselors to think beyond the therapy room and consider how sexuality counseling can be enhanced through connections within the broader community context.

OVERVIEW OF THE REMAINDER OF THIS BOOK

The rest of the chapters in this book will delve deeper into the various sexuality-related concerns that can impact clients. We begin by focusing on general strategies for clinical assessment and interventions in Chapters 2 and 3, respectively. The remaining chapters each cover the different levels in the Contextualized Sexuality Model, in order to provide readers with an understanding of unique considerations at each level. Throughout the book, our aim is to present a comprehensive, in-depth, practice-focused overview of sexuality counseling to equip counselors and trainees with the information and intervention strategies needed to effectively work with clients who are facing sexuality-related issues. We hope that readers will find this book to be a useful resource in helping clients navigate the complexity of the sexuality-related concerns they face.

KEYSTONES

- Despite their professional training, counselors are not immune to the discomfort surrounding sexuality.
- Clients often seek counseling for concerns related to their sexuality, whether as their primary concern or as a secondary concern to more pressing issues.
- Sexuality is an essential topic for counselors to become competent to address in their work.
- Based on the Contextualized Sexuality Model, the contextual influences on human sexuality include physiology, developmental influences, psychology, gender identity and sexual orientation, intimate relationships, cultural and contextual influences, and positive sexuality.
- Recently, the sex-therapy field has shifted to a more comprehensive, systemic approach to understanding and treating sexual concerns.
- The main distinctions between sexuality counselors and sex therapists are the degrees of the intensity of the treatment and the complexity of the cases.
- Professionals must understand their own level of competence to address sexuality-related issues in their work.
- Counselors should strive to increase their comfort in talking about sexuality in a professional context.
- Sexuality counseling presents counselors with unique ethical considerations that reflect the sensitive and personal nature of the subject of sexuality.
- Sexuality is an interdisciplinary topic that can be addressed on many different levels. Counselors working with clients on sexuality-related concerns should consider other community resources that may help clients make further progress toward their treatment goals.

ADDITIONAL RESOURCES

- American Association of Sexuality Educators, Counselors, and Therapists (AASECT; http://www.aasect.org/)
- American Counseling Association *2014 Code of Ethics* (ACA; http://www.counseling.org/docs/ethics/2014-aca-code-of-ethics.pdf?sfvrsn=4)
- Sexuality Information and Education Council of the United States (SEICUS; www.seicus.org)
- Society for Sex Therapy and Research (SSTAR; http://www.sstarnet.org/)