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Integration of Sex and Sexuality Into Counseling Programs

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Abstract

Many Americans have sexual dysfunction or behavioral concerns and are seeking assistance from mental health clinicians. Unfortunately, there is limited curriculum on sexuality counseling and sexual behavior in clinical mental health counselor education programs. This lack of education and discussion can result in counselor bias and lack of self-efficacy in therapeutic sessions. Researchers have found that medical assistance alone does not offer effective results when discussing sexual dysfunction or non-normative sexual behavior. Individuals engaged in various counseling interventions alongside sexuality counseling found reduction in sexual dysfunction and comorbid symptoms, such as anxiety or depression. This literature review seeks to highlight the prevalence of sexual dysfunction and different sexual behaviors facing possible clients, the existence of counselor bias and its effect on sexual topics in counseling, and the need for sex and sexuality to be integrated into counseling programs.

Keywords: counselor education, sexual behavior, sexual dysfunction, sexual health

In today's Western world there is hardly anywhere you can go where sex is not a topic of discussion. With popular books and movies such as *Fifty Shades of Grey* and *Magic Mike XXL*, it is clear that our society is interested in sex. This places counselor educators in the position to prepare budding counselors to discuss sexual topics in session. For example, after substance abuse, sexual concerns are among the most common problems reported among women to health professionals (Mize & Iantaffi, 2013). The Global Online Sexuality Survey (Shaeer & Shaeer, 2012) reported that 38% of American men experience sexual dysfunction. Thus, the reality that Americans experiencing sexual dysfunction will seek help from clinical mental health counseling professionals seems likely. This is particularly true given that sexual dysfunction not only affects individuals' overall health and wellness, but other relationships in their lives as well. Counselor education programs prepare students to work with a myriad of individual concerns and dysfunctions but often leave the subject of sexual dysfunction, behavior, and wellness untouched (Dupkoski Mallicoat, 2014).

Sexual dysfunction is not the only sexual concern that could present itself in session; people who participate in various sexual behaviors could already be in counseling for other concerns, or clients could be experiencing anxiety about engaging in new, non-normative sexual activities (Pillai-Friedman, Pollitt, & Castaldo, 2015). For instance, at least 11% of women and 14% of men have engaged in some sort of consensual, non-normative sexual activity, including bondage and discipline (BD), dominance and submission (Ds), sadism and masochism (SM), slave and master relationships, fetishisms, and kink activities (Kelsey, Stiles, Spiller, & Diekhoff, 2013); these activities fall under the all-inclusive term BDSM.

In a study conducted by Kelsey et al. (2013), therapists were asked if they had any clients exhibiting differing sexual behaviors, and 76% of the clinicians reported having at least one client in that category. However, only 48% of clinicians felt competent enough to provide effective therapy (Kelsey et al., 2013). When clinicians were asked questions concerning whether various non-normative sexual behaviors were healthy, 50% of clinicians were uncertain about how to answer and indicated they neither disagreed nor agreed (Kelsey et al., 2013). Due to lack of knowledge and understanding about client lifestyles, clinicians may be providing treatment to clients with various sexual dysfunctions and behaviors but are not confident in the treatment that they are providing. While Kelsey et al. (2013) provided information on clinician interaction with BDSM clients, the study is not without its limitations. The study only had a 9% participation rate and due to the small sample size, it cannot be representative of all clinicians (Kelsey et al., 2013). Further, the authors also believed that those who responded would have already felt comfortable discussing non-normative sexual behavior and this could have impacted their data (Kelsey et al., 2013).

It is clear that clients with varying sexual behaviors and dysfunctions are coming to mental health professionals for assistance, yet clinicians may not be receiving effective training in sexual behavior, dysfunction or therapeutic techniques in their counselor education programs. Kelsey et al. (2013) stated "Most [programs] do not provide much education on LGBT, polyamorous and BDSM subcultures in their curriculum, internship training or even textbooks" (p. 257). For clinicians to gain more information on sexual behavior or dysfunction, they must seek postgraduate training (Dupkoski Mallicoat, 2014). This is certainly a problem if clients are expecting clinicians to provide services

for their sexual needs. Other researchers have found that the majority of clinicians received no training in sexual diversity, including asexuality, transgender experiences, polyamory, and other sexual behaviors viewed as non-normative by the macroculture (Miller & Byers, 2010; Sarrel, Sarrel, & Faraclas, 1982).

Studies have shown that clinicians trained in sexuality counseling have more positive attitudes and feel more confident working with clients presenting with those issues (Pillai-Friedman et al., 2015). Training surrounding sexuality counseling can also improve counselor self-efficacy. Self-efficacy refers to the extent to which an individual believes they are capable of handling challenging situations (Pomeroy & Clark, 2015). Clinicians who feel more capable through effective training and discussion will be more likely to succeed in various situations (Pomeroy & Clark, 2015). Effective training around sexual behaviors and sex therapy in counseling education programs could increase self-efficacy among clinicians, ensuring that counselors entering the field are prepared to work with clients in this area.

Sexual Dysfunction and Related Factors

Sexual dysfunction can be anything that is an impediment on the enjoyment of sexual activity (Wakley, 2005). Sexual dysfunction is associated with poor quality of life and is linked to other comorbid symptoms (e.g., anxiety or depression; Blair, Arnow, Haas, & Millheiser, 2013). Sutherland (2012) reported that people experiencing sexual dysfunction, including discomfort or pain, also experienced vulnerability, guilt, shame, fear of rejection, feelings of inadequacy, hopelessness, loneliness, isolation, anger, negative self-talk, and discouragement. Mental health professionals spend a majority of training addressing the issues listed above; however, these issues are frequently addressed in an isolated fashion without talking about the link to the sexual lives of clients. Therefore counselor educators should address sex and sexuality concerns in counseling programs to prepare counselors in training.

Research has shown that 45% of women (Pereira, Arias-Carrión, Machado, Nardi, & Silva, 2013) and 38% of men (Shaeer & Shaeer, 2012) struggle with some sort of sexual dysfunction. Among women struggling with sexual dysfunction, 35% struggle with orgasm difficulties (Pereira et al., 2013). Pereira et. al (2013) stated that 75% of women achieve orgasm through clitoral stimulation. Two main ways that women achieve self-clitoral stimulation is manually and with vibrators. Fahs and Swank (2013) reported that 53% of women in the United States use vibrators. Use of vibrators and masturbation among women has been linked to increased sexual desire, arousal, lubrication, and orgasm. Use of vibrators and masturbation are also linked to absence of sexual difficulties and overall pleasant sexual function (Fahs & Swank, 2013).

Sexual dysfunction can also be brought about by medical causes. Breast cancer is a major concern among American women, and sexual dysfunction is often a result of the treatment necessary to fight cancer (Hummel et al., 2015). Studies have shown that breast cancer survivors typically experience worse sexual functioning compared to women who do not have a history of cancer (Hummel et al., 2015). Women who have received chemotherapy are also at a higher risk of sexual dysfunction, since chemotherapy can cause premature or even abrupt menopause. Sexual intimacy is facilitated through a biological process called vasocongestion, which is increased blood flow through the

vagina (Boyer, Pukall, & Holden, 2012). This process is triggered by female arousal and brings about lubrication. Lubrication allows for a more comfortable and pleasurable intercourse experience. Participation in chemotherapy can disrupt this process and can cause vaginal dryness and atrophy, affecting a woman's sexual function and enjoyment (Hummel et al., 2015).

Medical changes are not the only issue with which breast cancer survivors struggle. Women who have undergone a mastectomy can feel a loss of sexual attractiveness and engage in negative self-talk (Hummel et al., 2015). Breast cancer survivors also complain of loss of femininity, fatigue, anxiety, depression, and loss of fertility. These symptoms can lead to a loss of desire and poor sexual health. Even the diagnosis of breast cancer can affect a woman's emotional well-being and quality of relationship with her partner. When breast cancer survivors were asked if they were, or had been, interested in seeking professional care about their sexual concerns, 40% expressed interest, yet only 7% ever engaged in such care (Hummel et al., 2015). Many of the women were uncomfortable discussing what the treatment had done to them and even expressed feelings of shame and guilt, as well lack of knowledge about how to return to their pre-cancer sexual lives (Hummel et al., 2015). When clinicians were asked how comfortable they felt about addressing sexual concerns of breast cancer survivors, mental health professionals expressed their discomfort and reluctance, this was attributed to time constraints, embarrassment, and lack of knowledge and experience in the area (Blair et al., 2013). Clinicians also noted that they were unaware of resources to provide holistic care. This disparity could be due to lack of training in counseling programs and speaks to the need for integrating sex and sexuality conversations into the counseling curriculum. It is also worth noting that there is an inadequate amount of literature on male sexual dysfunction and its correlation to mental health.

In a 2009 U.S. national study, only 20% of men and women reported talking to their clinicians about sexual complaints or concerns (Blair et al., 2013). Even with these startling numbers, 70% of respondents felt as though clinicians should be discussing sexual issues with their patients and wished that they had spoken to a health professional about sexual concerns (Blair et al., 2013). Due to clients feeling uncomfortable addressing sexual concerns, it was suggested that clinicians receive training about how to ask questions surrounding sexual history, sexual health, and sexual complaints—the assumption being that clinicians should be more proactive in asking clients about sex, not simply waiting for clients to offer information.

Expectations of Sexual Behavior

In our society, there are certain sexual storylines that lay the foundation for how men and women talk about sex. Structural societal factors shape the ideals and perceptions about sexual behavior and sexual interaction. Many times these structures leave out other sexual behaviors viewed as non-normative, including sexual interaction in the LGBTQ community, people in open relationships, and individuals engaging in BDSM, to name a few. Clients who do not follow sexual scripts may ask themselves why they enjoy these behaviors, why they have these feelings, and why they are left out of the sexual and mental health conversations (Kelsey et al., 2013). When counselor educators

incorporate sex and sexuality conversations into their curriculums it prepares clinicians to address the aforementioned feelings and concerns.

Studies have shown that the media have a significant impact on beliefs toward sexual responsibility and sexual expectations. Mainstream media often communicate the expectation of an orgasm. Studies have shown that men and women anticipate achieving an orgasm during a sexual encounter (Cabrera & Ménard, 2012). Another piece to sexual interaction is that the male orgasm signals the end of the sexual encounter. Furthermore, simultaneous orgasms, where both man and woman achieve an orgasm at the same time, are often glorified in movies and books and inaccurately portrayed as “the norm.”

Although only 25% of women achieve orgasm through penile penetration (Pereira et al., 2013), helping a woman achieve an orgasm is deemed important to the male experience (Cabrera & Ménard, 2012). Indeed, research indicates that both men and women will fake orgasms during intercourse in an attempt to fulfill this sexual ideal. Cabrera and Ménard (2012) reported that men and women believe that sex without an orgasm is pointless. The fact that men and women feel the need to fake orgasms is yet another indicator of the discrepancy between reality and the expectation of a sexual experience.

The Media

The media often depict partnered sexual pleasure as a function of male technique. If a woman fails to have an orgasm from vaginal penile penetration, the impression is that the man is inadequate as a sexual partner (Cabrera & Ménard, 2012). This expectation can bring about male anxiety. Likewise, if women fail to achieve a single or multiple orgasm from their partner, then women may view their bodies as faulty, resulting in negative self-talk and anxiety about engaging in sexual acts (Blair et al., 2013; Pereira et al., 2013). Clinicians can prepare themselves for these conversations in counseling programs that view sex and sexuality as viable conversations for the classroom.

The media also portray women as playing a passive role in their sexual experiences. Scenes where men are holding women down, taking the lead, removing clothing, and controlling the speed and experience of a sexual encounter are typical (Cabrera & Ménard, 2012). When women are shown achieving an orgasm without their partner, there is associated shame and guilt. One line from a romance novel stated that the woman was “selfishly taking her pleasure” (Cabrera & Ménard, 2012). This idea of selfishly exploring one’s body alone and having a sexual experience alone is not limited to romance novels. Fahs and Swank (2013) found that although 53% of women use vibrators for sexual pleasure, heterosexual women are more likely to feel guilt and shame during usage; and when using vibrators, women felt more comfortable with clitoral stimulation than with vaginal penetration. These women cited the belief that their male partners could not adequately compete with a sex toy (Fahs & Swank, 2013). They also thought that inserting a dildo into the vagina for pleasure was challenging their male partners’ sexual power. It is worth noting that lesbian women did not view dildos or vibrators as masculine and thus found them fun and enjoyable; lesbian women also felt less shame about using sex toys (Fahs & Swank, 2013). If clients desire to discuss the feeling of disconnect between their personal sexual beliefs and those that the media portrays, counselor educators need to ensure that their students are well informed and aware of their own sexual beliefs.

Traditional Sexual Behavior and Interactions

The idea of male dominance in sexual situations and female passivity reinforces the ideals of traditional heterosexual cisgendered sex roles. Not only is this a concern for men who are more passive, or for women who are more assertive, but such contradictions pose a concern for sexual encounters in the LGBT, BDSM, polyamorous, or other communities. This limited idea of sexual behavior also neglects the sexual diversity of people in other cultures.

Certain sexual behaviors may be viewed as non-normative and subsequently shunned by society. Sexual interactions in the BDSM community can have negative societal implications, and mental health counselors can mirror such suggestions (Kelsey et al., 2013). Kelsey et al. (2013) asked 175 members of the BDSM community about their interactions with therapists, and participants stated that they felt judged. Participants stated that therapists did not have, nor desired, knowledge about their lifestyles, thus leaving participants feeling uncomfortable. Furthermore, individuals feared that therapists would assume they were victims of sexual abuse in childhood or adulthood. Part of the concern is that aspects of the BDSM lifestyle (e.g., sexual sadism, sexual masochism) are defined as paraphilic disorders (American Psychiatric Association, 2013). Diagnosis of paraphilic disorders are applied where sexual behavior is not appropriate or even harmful. However, when consensual and done properly, BDSM activities are generally safe. There is also no evidence that individuals who participate in BDSM are more likely to have mental disorders (Kelsey et al., 2013; Pillai-Friedman, Pollitt, & Castaldo, 2015).

Another traditional view of sexual behavior is monogamy. For many couples in the United States, monogamy does not define their relationship. Beyond infidelity, people do not often discuss non-monogamous relationships. Nonetheless, open relationships do exist, and participating individuals could be clinical mental health clients. There are data showing that open relationships can be healthy, fulfilling, and long lasting (Zimmerman, 2012). An open relationship is any relational structure that is not monogamous. Open relationships do not constitute infidelity because sexual boundaries are agreed upon, leaving no deception about any sexual relationship or behavior. At their core, open relationships usually have two individuals who are primary partners, and relationships outside of the primary relationship are viewed as secondary (Zimmerman, 2012).

“Open relationship” refers to numerous forms of consenting relationships. Partnered monogamy refers to a committed couple that allows for sexual encounters outside of the partnership. “Swinging” refers to non-monogamous sexual relations in social contexts, wherein couples engage in sexual activities with each other. Relationships allowing for more than one relationship (sexual, loving, or emotional) are referred to as polyamorous relationships. Solo polygamy is a non-monogamous individual who does not want a primary partner and has several sexual and emotional relationships. Polyfidelity relationships are three or more people who are in a committed relationship together. These relationships ensure that all individuals involved are primary partners and that the emotional and sexual interactions are spread throughout the relationships. Counselor educators, and subsequently their students, should be aware of the variety of relationships that clients can engage in and appropriately work to educate their students.

Counselors' Biases

Crowe and Averett (2015) discovered that it is overly simplistic for mental health professionals to think they are immune to stereotypes, stigma, and biases. Counselors are compelled to evaluate their ideas, attitudes, and values, including those related to sexual behaviors and activities, to lessen the threat of bias in session. Counselor bias is not a new phenomenon. Feisthamel and Schwartz (2009) found that mental health clinicians are more likely to diagnose African-American clients with a psychotic disorder when reporting spiritual experiences or encounters. When European-American clients described similar events, clinicians tended to diagnose a mood disorder—a more “cautious” or benign approach to diagnosis not afforded clients of color. In the same study, clinicians disproportionately diagnosed African Americans with psychotic and childhood behavior disorders. Crowe and Averett conducted a study surrounding counselor bias toward mental illness. They found many clinicians were biased toward certain mental health illness disorders, attributing stereotypical characteristics even when not present. Studies such as these show that counselor bias does exist and can have negative consequences if not addressed.

Since client symptoms can be complex and diagnosis can contain a subjective measure (i.e., clinical judgment), clinicians with bias are at risk of malpractice (e.g., inaccurate diagnosis; Feisthamel & Schwartz, 2009). A clinician’s view of and comfort level with sexual topics can influence the therapeutic relationship (Miller & Byers, 2010; Pillai-Friedman et al., 2015). If a clinician is uncomfortable discussing these topics or feels professionally inadequate, the client may become uncomfortable, refusing to discuss sexual proclivities and thus impairing the counseling process (Miller & Byers, 2010).

Counselor education includes awareness of and respect for varying cultures, but research suggests that “sexual culture” is omitted (Zimmerman, 2012). Some counselors believe members of the American Psychological Association should consider those engaging in BDSM or other non-normative sexual behaviors (e.g., open relationships) as a sexual minority group (Pillai-Friedman et al., 2015). Therapists should not only be aware of sexual messages clients are receiving through media, the reality of sexual interactions (including those in the LGBT community and BDSM community), but should also be aware of the different ways individuals engage in sexual and emotional relationships (Pillai-Friedman et al., 2015).

The literature suggests that clinicians have the opportunity to explore their biases and become comfortable with their own sexuality through education (Zimmerman, 2012). If clinicians fail to explore their personal biases, it could result in countertransference (Turns, Murriss, & Lentz, 2013). Only through education and exploration can clinicians learn to avoid assumptions and stereotypes, as well as become comfortable talking about sex, sexual behavior, non-monogamy, and open relationships (Miller & Byers, 2010). Clinicians can be taught how to use theories and techniques to assist with client sexual dysfunction, sexual behaviors, and open relationships (Sarrel et al., 1982). Newly-minted counseling professionals and counselors-in-training would particularly benefit from this education and explorative learning.

Integrating Sex Therapy Into Counseling

The Greeks and Romans viewed sexual dysfunction as an illness brought on by spiritual or physical factors (e.g., age, infirmity, witchcraft; Berry, 2013). During the Age of Enlightenment, there was a move towards medical reasoning for understanding sexual dysfunction. Puritanical views influenced modern ideas of sex, valuing sexual activity within the confines of marriage, occurring between one man and one woman, in order to produce children (Dupkoski Mallicoat, 2014). Between the 1800s and the 1930s, sexology became an official interest area, with Sigmund Freud and modern-day psychiatry impacting the field (Berry, 2013). Recently, biomedical and pharmaceutical treatments (e.g., Viagra) have taken a strong hold in sex therapy and treatment.

Unlike earlier interventions, the main goal of modern sex therapy is to reduce anxiety related to sexual activity and to improve the client's sexual repertoire (Pereira et al., 2013). Therapy may include muscle relaxation techniques, emotional expression and reflection, and communication skills. Communication skills include active and passive listening, verbalization and reflection of feelings, conflict management, and training in assertive behavior. Sex therapy also includes masturbation training for facilitating sexual awareness. Mindfulness training also assists with this goal, helping clients become aware of the moment, of what their bodies enjoy, and of what to encourage or discourage (Mize & Iantaffi, 2013).

Cognitive behavioral therapy (CBT) is also used in conjunction with sex therapy and sexuality counseling (Corey, 2005). Pereira et al. (2013) conducted research with couples who struggled with hypoactive sexual desire disorder. These six couples engaged in sex therapy coupled with CBT for 2-hour sessions for 12 weeks. Therapy sessions included psychoeducation, sensate focus exercises, communication skills, positive reinforcement for preferred sexual activity, cognitive restructuring, and sexual fantasy training with two therapists trained in CBT and sex therapy. Seventy-four percent of the couples who participated in all of the activities said they benefitted from treatment due to decreased symptoms (Pereira et al., 2013). Limitations to this study included the small sample size not being representative of the population.

In other research, women who suffered from vulvodynia, or vulvar pain, (Boyer et al., 2012) and women who were breast cancer survivors (Hummel et al., 2015) reported that they benefitted from CBT coupled with sex therapy. Therapy included groups of women of varying ages and races. Both groups worked on sensate exercises, which are structured activities where individuals can gradually reintroduce phases of sexual contact (Pereira et al., 2013). These exercises allow women to become comfortable with their bodies and/or partners, leading to higher sexual, physical or emotional intimacy. Out of the women with vulvar pain, there was a 33% reduction in pain score; additionally, the women continued to use their learned techniques with increasing improvement over time.

Likewise, existential therapy has been implemented when working with men and LGBT couples. Existential therapy helps clients understand their larger place in the world and the importance of connecting during sexual interaction. Both groups said their sexual dysfunction improved (Rutter, 2012; Milton, 2014).

Implications for Counselor Educators

The professional literature suggests that it would behoove counselor educators to integrate sex therapy into counseling programs. Having effective training in sexual dysfunction, sexual expectations, and general sexual psychoeducation can increase self-efficacy for counselors. The literature regarding self-efficacy and counselor education supports the claim that effective training increases self-efficacy for budding counselors and supervisors (Motley, Reese, & Campos, 2014).

Sex therapy has been reserved as a hidden specialization confined to marriage and family therapists. The 2016 Council for Accreditation of Counseling and Related Educational Programs (CACREP) standardizes educational requirements for sexual counseling in two specialty areas, specifically, Marriage, Couples and Family Counseling and Clinical Rehabilitation Counseling (Dupkoski Mallicoat, 2014). The fact that sex therapy has only been reserved for marriage and family therapists is problematic for clinical mental health counselors. Sexual counseling is not singularly within the purview of married couples.

Mental health counselors are also finding employment in hospitals and treatment centers where clients could be facing medical issues, such as breast or prostate cancer, which can have an effect on sexual interaction (Hummel et al., 2015). Furthermore, since sex and sexuality is a human experience and not unique, it is almost certain that counselors will engage in a conversation about sex with their clients, whether they are single, married, or in an open relationship. It also seems likely that clinical mental health counselors will not only encounter clients with sexual difficulties, but also comorbid symptoms that may accompany these issues. Counselor educators can assist in the preparation for this process.

Counselor educators regularly prepare their students to discuss depression, anxiety, and irrational cognition with their clients, and counselors-in-training are extensively taught and trained how to do so. However, when those same affective symptoms present in the therapist's office surrounding sexual concerns, the same counseling student may fall short due to lack of training and education. Sexual concerns are currently viewed as more of a medical issue treatable with medication. This contextualization of sex as a medical issue may have increased clinical mental health counselor's discomfort in addressing sexual concerns and issues (Dupkoski Mallicoat, 2014). While it is fairly common for clients with sexual concerns to reach out to a medical professional, medical and mental health professionals agree that a more holistic approach on sex therapy is the most effective treatment. This holistic treatment includes addressing sex in a medical, social, cultural, and political context.

Since medical and mental health professionals are looking to make sex therapy more inclusive and holistic, this may change the way that sex is viewed in counseling programs. Sexual training can be incorporated into clinical mental health curricula. Sex therapy and sexual training can be woven into existing coursework that is already part of CACREP standards (CACREP, 2015). Classes with topics surrounding addiction, human development, research, or even multicultural counseling can become a backdrop to engage in an educational conversation about sex. This can be achieved in the classroom through role play, case studies that have sex and sexuality-centered concerns, or open discussions about sexual bias and beliefs. Concentrations or certifications are other ways

to bring instruction to counselor education students. Another option is to require clinical mental health students take courses on sexuality counseling. Finally, counselor educators can always promote research in this important area.

Future Areas for Research

While there is information about how to integrate sex therapy and clinical mental health counseling, there are also limitations to the field. There is not enough information about sexual concerns in the LGBT community. Ideas perpetuating negative stereotypes (e.g., LGBT community and HIV/AIDS) should not serve as a foundation to counseling sexual inquiries (Rutter, 2012). Also, while there are numerous studies about how women view sex and their concerns regarding sexual dysfunction and expectation, this research is lacking in regards to male sexual dysfunction.

Further research should also be conducted on cultural sexual diversity. Counselors are taught that different cultures communicate, eat, dress and interact differently; however, the way these cultures view sexual interaction and intimacy is lacking in counselor education programs and in the literature. Cultural views of sexual interaction may conflict with individual attempts to acculturate into American life. Therapists must also consider intercultural relationships and how sex and race/ethnicity intersect and affect sexual expression, interaction, and intimacy. Also, race and ethnicity should be examined, as there is minimal research on how the intersectionality of race and gender with sexuality could cause emotional anguish.

There are many factors that influence how clients think and feel about sex. First, sexual dysfunction concerns that do not follow the script of sex are more prevalent than we realize, occurring in both men and women. Sexual dysfunction can be brought on by severe medical conditions, such as breast cancer or menopause, or by anxious feelings about performance (Boyer et al., 2012; Hummel et al., 2015; Sutherland, 2012). Sexual dysfunction occurring in men and women also comes with comorbid symptoms such as depression or anxiety. Second, clients may not be fully educated about the differences between real-life sexual experiences and those portrayed in the media (Cabrera & Ménard, 2012; Fahs & Swank, 2013). All too often, clients have unrealistic sexual expectations. Clients may find themselves confused, unsatisfied, and subject to negative cognitions about themselves or their partner. Finally, sex therapy accompanied by counseling and medical techniques provides the most effective and long-lasting positive outcomes for clients (Pereira et al., 2013).

The literature suggests that clinical mental health clients are asking for assistance. Preparing clinicians to meet this call is important, and, accordingly, counseling professionals are compelled to engage in proper training preparation to enhance best outcomes for their clients. Future studies should also focus on increased sample size and diversity of the samples to ensure that the data is representative of the population of counselors and counselor educators. Lastly, there is no research on whether counselor educators have a bias or aversion to discussing sex and sexuality in the classroom.

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