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# Too Taboo?: Preliminary Explorations of Counselor Experiences of Client Sexuality

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For many years, researchers and clinicians have discussed the weakness in the counseling profession surrounding education and training specific to sexuality. Previous research has largely focused on quantitative approaches to explore why client sexuality is a source of discomfort for counselors. This study sought to explore the qualitative experience of two counselors to begin filling in the gaps left by similar quantitative research. Through narrative interviews, themes related to avoidance of and motivators for discussing sexuality with clients were identified. Results from this research can help influence counselors in practice, counselor educators and future areas of sexuality counseling research.

*Keywords:* counseling, human sexuality, counselor education, narrative inquiry, qualitative research

## Introduction

The experience of one's own sexuality can be influenced by a multitude of physical, emotional and social elements (Buehler, 2014). For individuals experiencing mental health strain, the likelihood of experiencing difficulty in their sexual lives is much higher than in the general population (Blalock & Wood, 2015; Southern & Cade, 2011). Mental health counselors, therefore, should be adept at working with clients regarding their sexuality. Given the nature of mental health counseling work, counselors are trained to discuss myriad difficult personal issues that clients need to process (Cochran & Cochran, 2015). Despite sexuality being an integral part of an individual's wellness (Buehler, 2014; Southern & Cade, 2011), psychological and biological development, and self-concept (Kleinplatz, 2012), the taboo nature of discussing sex remains challenging for counselors to broach. If counselors maintain a philosophy of holistic wellness, they must be able to explore a client's sexuality as part of the therapeutic process.

Mental health counseling practitioners are very likely to work with a client who is experiencing some level of problem in their sexual life that is tied to their emotional functioning (Southern & Cade, 2011). Previous research indicates that a majority of mental health professionals avoid, defer, or ignore their clients' concerns related to sex (Harris & Hays, 2008; Reissing & Giulio, 2010). Factors that may hinder counselors from having sex-related conversations with clients include a lack of training or education, their personal values related to sex, and a fear of ethical violation (Reissing & Giulio, 2010; Wiederman & Sansone, 1999). Whatever the reason, when a counselor does not address sexual issues with clients, they are missing a key aspect of the client's whole experience, often with negative consequences

for the client (Buehler, 2014; Southern & Cade, 2011).

Many counselors appear to struggle with appropriately recognizing, acknowledging, and addressing sexual concerns with clients (Miller & Byers, 2011; Reissing & Giulio, 2010; Wiederman & Sansone, 1999). In particular, the research suggests that a number of personal and professional factors influence how a counselor experiences the subject of client sexuality (Miller & Byers, 2011; Reissing & Giulio, 2010). After a thorough review of the literature, it is evident that a majority of research on the topic has utilized quantitative design (Hanzlik & Gaubatz, 2012; Harris & Hays, 2008; Miller & Byers, 2011; Russell, 2012; Wiederman & Sansone, 1999) that limits participant response and exploration of the myriad influencing aspects of a counselor's experience of client sexuality (Bochner & Riggs, 2014a). Furthermore, similar studies focus on the experiences of health care professionals outside of the profession of counseling (Abdolasulnia et al., 2010; Hanzlik & Gaubatz, 2012).

The purpose of this research is to pilot a broader study exploring the experiences of mental health counselors who have worked with clients with sexual concerns. As a preliminary exploration, two participants were utilized to iden-

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tify relevant inquiry paths and establish a methodological approach. In an effort to supplement the quantitative data that previous researchers have collected, this study sought to hear more of the personal experiences that counselors have when working with client sexuality. What follows is a brief review of the literature and subsequent discussion of the specific methods used for this study and the resulting themes. Finally, there will be an exploration of implications for future research, counselor education and counseling practice.

### Literature Review

For nearly four decades, researchers in the field of mental health care have examined how mental health professionals encounter sexual topics (McConnell, 1976; Reissing & Giulio, 2010). Much of the research conducted has pointed to a major deficit in this area of professional ability, training, and confidence about client sexuality (Southern & Cade, 2011; Wiederman & Sansone, 1999). This dearth in the field is somewhat confusing given the fact that sexuality has been a topic of focus since the early years of psychology as a line of study (Apfelbaum, 2012; Southern & Cade, 2011).

### Counselor Sex Education

Mental health counseling, as a relatively new professional field, has worked to gain footing and security in the realm of mental health care. Regardless, the absence of human sexuality in not only counselor training but in mental health professions as a whole has not gone unnoticed. One of the first studies to explore this issue was a review conducted by Gray, Cummins, Johnson, and Mason (1989). Their focus was on how coursework focused on sex in counselor education programs was presented to students as either discrete courses or embedded into other content. What was revealed from participant responses was that most of the training programs surveyed integrated material with other coursework. Sexuality courses were rarely required for students. When sexuality content was present, most of the emphasis was placed on content rather than attitudes about sex.

A more recent but still dated examination was conducted by clinical psychologists in Canada who developed a survey regarding a variety of clinical practices associated with client sexuality (Reissing & Giulio, 2010). Most of the respondents reported that they rarely initiate conversations about sexuality with their clients. Furthermore, despite responding that they had received minimal training about specific sexual treatments, they also indicated that they have recommended sex therapy techniques for clients.

Updated information about if, how, where, when, and by whom sexuality is taught in counselor education curricula is desperately needed. At this time there is very limited data to inform assumptions about whether or not professional counselors have the opportunity to receive direct education about sexuality. The extent and format of that education is likewise

unknown. Based on the prior examples, it seems likely that sexuality education continues to be rare in counselor education spaces, and even if education is received, the impact of that education may be insufficient to impact clinical practice.

### Client Harm and Ethical Considerations

Counselors who do not address sexuality with their clients run the risk of their client seeming to stall in counseling, leaving them to continue experiencing sexual and emotional distress (Buehler, 2014). Many clients who experience sexual issues struggle with initiating conversations about sex with their counselors, frequently because of socially reinforced sexual shame and secrecy. Research has shown that if a counselor does not initiate and normalize the discussion of anxiety-provoking topics, chances are that the client will not bring the issue up themselves (Russell, 2012).

Personal values about sexuality can further influence a counselor's willingness to address sex with clients (Pillai-Friedman, Pollitt, & Castaldo, 2014). Pillai-Friedman et al. (2014) propose that, oftentimes, clients will not honestly disclose their sexual preferences to their counselor. Specifically, clients who experience kinky or what may be perceived as non-normative sexual arousal may run the risk of being pathologized or judged by their counselor if they openly discuss their sexuality (Pillai-Friedman et al., 2014). If mental health professionals are not properly educated about human sexual behavior and provided with a space to acknowledge and process personal values related to sex, they may attempt to push beliefs about normalcy onto their clients. This would of course be in direct violation of the American Counseling Association's (ACA) clearly articulated ethical codes regarding imposing one's own "values, attitudes, beliefs, and behaviors" (ACA, 2014).

Finally, under this umbrella of limited sexual education in counseling, sexual ethics is a major concern for the profession as a whole (Hamilton & Spruill, 1999). Houseman and Stake (1999) studied how well clinical psychologists are trained in sexual ethics. The students surveyed reported some level of sexual ethics training. However, they also revealed a deficit in knowledge about how to deal with sexual feelings or relations with current or former clients. Most concerning from this study is that those students with the lowest understanding of sexual ethics were also least willing to discuss sexual attraction to clients with a supervisor. Current research examining if or how this trend may have changed among counselors in the intervening 20 years is lacking. Some articles do explore the need to continue addressing sexual topics in training for marriage & family therapists (Zamboni & Zaid, 2017) and clinical psychologists (Barnett, 2013). While resources exist that identify how professionals can manage sexual dynamics in clinical settings from a variety of perspectives (Celenza, 2011; Luca, 2013) when, how, and to what extent this topic is covered in educational

settings or applied in clinical settings is still murky. If an understanding of sexual ethics and comfort with discussing sexuality is not present to mediate the counselor's naturally occurring attraction, ethical violations related to sexual relationships with clients are more likely to occur.

### **Problem Statement & Purpose**

Previous research strongly indicates that mental health counselors are likely lacking aptitude and awareness regarding sex-related dynamics impacting the counseling relationship. Furthermore, the voices of counselors has thus far been absent in the literature exploring this issue. The current study seeks to begin filling this gap, contribute to a clearer understanding of why this resistance to sexuality persists, and determine what can be done to correct this aspect within the counseling profession.

It is hoped that the information gathered from the interviews of this study will contribute to a better understanding of how mental health counselors experience their clients who discuss sexuality within the counseling setting. This improved understanding not only gives voice to the unheard experience that the literature has thus far ignored but may also influence how clinicians, supervisors, and counselor educators choose to approach the issue of human sexuality within the training and development of professional counselors.

### **Methods**

#### **Researcher Philosophical Stance**

The majority of research exploring the relationship that counselors have with sexuality has been quantitative in nature (Harris & Hays, 2008; Miller & Byers, 2011; Reissing & Giulio, 2010; Russell, 2012). A qualitative approach can offer a different perspective on the issue and complement the valuable generalized data of these prior studies. Rather than seeking breadth, qualitative approaches allow researchers to explore deeper aspects of participants' lives (Clandinin, 2013). As such, large sample sizes are unnecessary given the intimate format of exploration (Bochner & Riggs, 2014b). Similarly, the pilot nature of this study required only a small number of participants to engage with the researcher to indicate a direction for future research.

For this research in particular, I selected narrative inquiry in order to give voice to my participants' experience (Clandinin, 2013). Grounding my approach in narrative style honors the unique perspectives of not only the participants that I interviewed but also that of my own lived experience. In particular, narrative inquiry acknowledges the integral way in which the researcher impacts and influences how participants respond and share their narrative within the context of the researcher-participant relationship (Bochner & Riggs, 2014b; Clandinin, 2013). My own perspectives will be interwoven throughout the following manuscript in order

to represent the interactive nature of this form of research (Hickson, 2015). I recognize that the brief interactions that are documented here are partial representations of my participants' whole experience and that my projections of the meanings of their stories are my own and not necessarily representative of their worlds (Bochner & Riggs, 2014b). From a narrative perspective, an impartial analysis is impossible due to the relational quality of the interview and analysis process (Riessman, 2007).

#### **Participants**

Because narrative inquiry seeks depth instead of breadth (Clandinin & Connelly, 2000) and the intent of this study to pilot a wider potential follow-up study, I decided to limit my interviews to two participants. Focusing on the constructed stories of these two individuals combined with my own lived experience was sufficient to explore the research questions (Clandinin, 2013). The participants of this research experience were two mental health counselors, Patricia and Linda (pseudonyms). Both are middle-aged white women with at least a master's degree working in private practice in the Rocky Mountain region of the United States. I personally have a close friendship with Linda and a casual working relationship with Patricia. They were both recruited by personal requests from me. Patricia has been licensed for counseling for over 10 years and has been practicing counseling for close to 25 years. She identifies as heterosexual and situates herself in an upper middle class socioeconomic status. Linda holds a PhD in Counselor Education & Supervision and is a provisionally licensed counselor. She identifies as "mostly straight" and self identifies as middle class.

#### **Interviews**

Semi-structured interviews were utilized to facilitate the participants' exploration of their experience of client sexuality. Each woman participated in one interview, which lasted roughly 1.5 hours. Both interviews took place in private, secure rooms located in clinical practice settings and were video recorded. I transcribed the interviews verbatim and electronic copies were sent to each participant of their own interview to give them the opportunity to review their statements and offer any clarifications following the conclusion of our time together.

#### **Data Analysis**

The data analysis followed a model of narrative-under-analysis (Bochner & Riggs, 2014b). By utilizing narrative-under-analysis, commonalities and themes between the two interviews through the lens of my own personal experience were explored. I utilized correspondence and pragmatic use to address the issue of trustworthiness for the constructed narratives. Participants were provided with their

final transcripts and emerging themes to maintain their engagement with my interpretation of their stories. The current manuscript, follow-up research by me and others, and related presentations connect with the pragmatism of the current study (Riessman, 2007). Additionally, while transcribing, I reflected on my own feelings during the interviews in an attempt to maintain a reflexive stance that is integral to narrative inquiry (Bochner & Riggs, 2014b). My own reflections and those of my participants are integrated into the presentation of results that follows.

## Results

Several common concepts arose during Patricia's and Linda's telling of their experience and my own experience of their stories. Both identified several components playing a role in how they respond to sexual topics in a clinical setting. Rather than focusing exclusively on barriers to discussing sexuality with clients, both interviews encompassed motivators to discuss sexuality and personal dynamics in addition to professional contexts.

### Barriers to Discussing Sexuality

**Training.** Patricia and Linda each discussed their academic training playing a role in their recollections of working with clients with sexual concerns.

*I guess I feel like I avoided the area. With some education I think it could have been a better conversation...How can I offer advice or guidance about that when it's not even in my scope of education? -Patricia*

*But we don't talk about sex, we don't know how to talk about sex, and we're not trained to talk about sex therapeutically. We don't know what it means. We're not trained on that, and so I think that's what gives it that taboo feel. -Linda*

This dynamic is the most obvious one supported by the literature (Harris & Hays, 2008; Reissing & Giulio, 2010). It was unsurprising to find that both participants articulated that sexuality was a missing component in their training. Linda's comment about educational silence contributing to the "taboo" feeling of sexuality feels important. There appears to be a parallel process of silence on multiple levels in relation to sexuality. Counselor educators and supervisors who do not broach the topic of sex with their students and supervisees send the message that it is not an appropriate topic to explore. This mirrors the clinical dynamic of counselors replicating that silence and therefore communicating to their clients that sex cannot be addressed in session.

**Clinical severity.** Patricia and Linda both explored a qualitative difference between working with a client who talks about sex in a non-specific way and working with a person with a 'diagnosable' sexual dysfunction.

*If I feel like somebody really has like a diagnosable sexual issue, that's when I feel like I would need help. -Linda*

*How do you teach someone to become orgasmic? I mean, there's probably certain things you do, certain terms. (For someone with) erectile dysfunction...what does a person do to help that? I mean I just don't know. -Patricia*

This distinction is an interesting one. In hearing, transcribing, and reflecting on these responses, I feel a sense of helplessness from Patricia and Linda, as if they feel somewhat confident to hold the space for a client to discuss their sexual lives, but within the context of specific treatment they are at a loss. An essential writing on the topic by Annon (1976) identifies that mental health professionals should be able to offer permission to clients to discuss sexuality and have limited information about the concerns therein. Ideally, clinicians should also be able to offer specific suggestions but reserve intensive therapy for a specialist (Annon, 1976). For both Patricia and Linda, it seems as though they have met a barrier at the stage of specific suggestions. This internal sense of a lack of education seemed to be contributing to insecurities surrounding accurately supporting clients with particular sexual diagnoses.

**Personal discomfort.** Similar to the results of the studies discussed in the literature review, personal discomfort was a part of both women's stories. For Linda this discomfort was related to accidentally showing fear and shock to clients. Patricia identified that her discomfort is more connected to a sense of privacy and inadequacy.

*I wasn't sure I trusted myself for that. I wasn't sure I trusted myself to stay in the moment of what was going on between all of us and not going "oh my god I can't believe you said that," or "oh my god I have this visual image," or "oh my god I'm super uncomfortable with this." I didn't trust myself I think. I still have a little bit of fear that somebody might say something that really repulses me. I still don't think it would keep me from doing it. But if they said something that really freaked me out or scared me or repulsed me that I might stop short. Or not explore it with them. -Linda*

*Also, I'm a very private person. I don't discuss that topic with friends. Of course, my husband and I talk about it, and I've had many*

*conversations with my children about sexuality but not like details about sex. I guess with them I've talked more about the emotional part. Some about the physical but not any of the specifics or the details because I feel like that's such a private topic. Well, I'd probably not be comfortable, and I probably would tell the secretary, "I think you better find somebody else." All I have to base it on is my own sexual experiences so but who knows if those are normal you know? Then like it's almost talking about myself in counseling and that would be very uncomfortable.* -Patricia

During analysis I was struck with the importance of identifying the details of how personal discomfort manifests when counselors are confronted with sexuality as a clinical topic. Linda's revelation that she is aware that there may be some sexual acts that could result in her displaying disgust to her client speaks to the fear of sexuality disrupting the therapeutic relationship. In Linda's mind, it appears sex is a unique topic that may elicit strong emotions for her. Her ability to bracket her personal reaction could be at risk if the content is of a sexual nature with her client. Conversely, Linda experiences sexuality as such an intimate topic that she is hesitant to broach it with them. Social stigma surrounding openly discussing sexuality is certainly a major factor for her. However, mental health counselors are expected to explore the most intimate and vulnerable parts of their lives. On reflection, it makes me wonder how she experiences other perceived intimate aspects of her clients' lives and what makes sexuality different compared to other value-laden subjects such as suicide or infidelity.

**Professionalism.** Lastly, both expressed a fear of being professionally inept when working with clients regarding sexual concerns. For Patricia, this was a combined sense of being prepared to refer a client with a sexual concern to someone else and also an acknowledgement that her values related to sex have been challenged by clients.

I think, in the past, there's always been other issues to talk about besides the sexual piece, so there's always something to divert to a different topic. I guess another thing that has made me uncomfortable is as I work (with) millennials, like, twenty-somethings, and a lot of times, and it's women that I've worked with, that will throw out the term "friend with benefits," I have a hard time with my values because I feel like it's a very dangerous path that younger people...so that's a topic that's made me uncomfortable too. It was hard to wrap my head around and say, "ok this is for them, they like this, it's comfortable for them, they like the non-commitment part too."

Patricia acknowledged that her values related to sex are something that she needs to be mindful of so that she doesn't place judgment or encourage her own values on her clients. She clearly has an awareness that she has an ethical obligation to monitor her values in her work (ACA, 2014) but it sounds as though she has not had the structured opportunity to express and explore her values to better attend to how they might arise and impact her clinical work. It could be that she is lacking the tools and external support to stay with the conversation rather than avoid it.

Linda, related to her discussion of personal discomfort, also connected her experience to a fear of remaining therapeutically present with a client.

It's the sex, talking about sex that makes me question, can I keep my counselor role? Can I keep it therapeutic? I can't think of many other topics that I would question myself about.

This threat has been identified in the literature as a cause for counselors to avoid the topic. Some have indicated that they fear addressing sexuality with counseling clients may open the door for ethical sexual violations (Hamilton & Spruill, 1999). More specifically, counselors are wary of themselves becoming aroused or attracted to their clients, being perceived as coming on to their clients, or that clients may invite inappropriate sexual advances from their counselors (Hamilton & Spruill, 1999). While Linda's fears don't seem to be quite to that extreme, they still speak to the connection that talking about sexuality does not align with the professional counselor role.

### Motivations to Discuss Sexuality

Several motivating factors to support the participants' willingness and ability to discuss sexuality also arose during our times together. These dynamics are important to explore so that viable options to strengthen the counseling field in this area may be developed.

**Having a catalyst or mentor.** Both women discussed having a particular person in their lives that has either inspired or forced them to become more comfortable with sexuality.

*My best friend...has worked so much with clients about sexual topics, and she had such a great attitude about it. She looked at it as a challenge that she could meet. I really used her as a role model.* -Linda

*Well, I think after working with the transgendered (sic) (client) I felt like I was surprised by that situation because I think I got the referral, it was for personal issues or something, so I don't think he told the secretary, "I'm struggling*

*with transitioning." So I was kind of surprised, but I was able to work with him on, letting him know, "I haven't worked with anybody that's been transitioning but I'm willing to learn" and being honest with the client. -Patricia*

I found myself feeling excited and grateful that both participants had a person in their lives who has pushed them to stretch their comfort zone related to sexuality. In this way, there is hope that one can impact another individual regarding their willingness to broach the topic of sex with clients. The ripple effect of one person openly talking about, normalizing, and educating others about sex is not to be undervalued. Patricia's self-stated openness to staying with a client whom she did not initially know was trans is likewise powerful. I find myself needing to balance my wish for her educational process to be less steep with pride that she is committing herself to work with this issue about which she has very limited knowledge.

**Self-confidence.** In very different ways, confidence in their ability to either continue their education about sexuality or manage their reaction in a therapeutic way impacted how both women discussed their experience.

*I think I have enough confidence in myself to know that I can educate myself. So I think I would be okay educating myself and just saying, you know this isn't like a real comfortable topic but let's tackle this. -Patricia*

*This all happened as I became more comfortable with my role of being a counselor. Whatever somebody says, it may take me a minute to regroup but I can trust myself. Therapeutically I can trust myself to re-engage. -Linda*

Ideally, all counselors enter the field with at least enough confidence in their clinical skills to remain present with a client regardless of the topic, but they should have mentors, colleagues, and supervisors to help them continue expanding their expertise. Unfortunately, Patricia's and Linda's reports are contrary to what some researchers have found in the past (Russell, 2012). Certainly, more information about how much specific education regarding sexuality in clinical settings is necessary to facilitate practical application is needed. Counselors may not need discrete coursework in sexuality. It may suffice to have the subject addressed in general academic or practical settings.

**Motherhood.** Unexpectedly, both women also discussed their obligation to their children as one area where they do not hesitate to discuss sexuality. Because I am not a mother myself, I did not anticipate this aspect of my participants' identity to impact their experience of sexuality.

*So I try to talk to my kids about it. Because, again, I feel like it's not just my duty but like my duty with my children. I'm trying to be really open. I'm trying to have this household where they're open. -Linda*

*Once he (her son) got a girlfriend it was like, okay, we got to really talk about this. But with me it wasn't like specifics about the act of sex, it was more the emotional parts like when you decide to have sex, and what is the impact, and you know, what helps you make the decision, those kind(s) of conversations. Which are, comfortable to me, and with clients too, but I don't, really talk about the actual mechanics. -Patricia*

**Supervision.** Linda specifically discussed the impact of clinical supervision on her comfort and confidence in sexuality in a clinical setting. She explored the risk that can come from "opening the box" of sexuality as it could lead to sexual feelings towards clients, which is a normal experience for counselors but is not often discussed (Hamilton & Spruill, 1999). Due to licensure differences, Linda is legally and professionally obligated to receive supervision whereas Patricia does not.

I think good supervision helps normalize that. (A)nd I think supervision and consultation is the key, just from what I know and what I'm learning, is the key to continuing to make ethical judgments, solid clinical interventions and keeping shame out of the picture. Finding someone who can say "that makes sense; it makes sense that you have this dream" or "it makes sense that you experience that feeling."

Supervision regulations and continuing education requirements vary widely by state. This offers another avenue to strengthen clinical practice. Regulating supervision requirements at a national level could promote initial and continued development of counselors. Moreover, supervisors themselves could receive some specific education about addressing sexual topics with supervisees. Another possibility would be for states to include regular continuing education credits related to sexual concerns.

## Discussion

### Limitations

My varying levels of personal relationship with each of these women likely impacted the way in which they told their stories. While narrative inquiry doesn't restrict research participation based on researcher-participant relationships, the dynamic should still be acknowledged. Linda and I have had

several conversations about sex and sexuality, both in personal and professional contexts; in a way, she was primed to discuss the topic. As a result, my own comfort with her in probing for her experiences or inviting her to expand was immediate. On the other hand, Patricia, being a private person and less familiar to me, took longer to become more comfortable with me and vice versa.

Additionally, at the time of these interviews my concept of narrative inquiry was in the earliest stages of development. From my current perspective, with a firmer grasp of my intentions and narrative research as a whole, I can see now how my questions were both very directive and also uncertain. I felt pressure to have a specific question answered, grounded in my history of engaging in quantitative positivist research, rather than foster an environment for them to discuss their experiences. I recognize a pressure in myself to probe for the answers that I was looking for rather than take whatever they had to share with me.

Follow-up interviews may have given greater insights into how Linda and Patricia experience client sexuality. I did contact them about their transcript with emerging themes and at that time asked them whether or not they had additional thoughts following our time together. While neither of them reported any further comments, a more formal follow-up interview could have expanded their narratives further.

Although not technically a limitation given the nature of qualitative research, additional narratives beyond the two offered here would paint a larger picture of how counselors encounter sexuality. Demographically, Patricia and Linda are both very similar and therefore their narratives have a number of overlapping components. Further research would benefit from exploring the storied experiences of counselors of color, queer counselors, counselors from varied educational backgrounds, and counselors from different regions. The more narratives that are explored will continue to give the profession a clearer understanding of not only how sexuality is lacking but also ways in which it is already being broached in myriad settings.

## Implications

From the experiences of these two women combined with my own perspective, there are clearly a number of aspects of sexuality as a clinical topic that can influence a counselor's experience of the subject in the counseling room. In alignment with prior research, lack of training appears to play a role in these women's work with sexual issues in counseling (Gray et al., 1989; Reissing & Giulio, 2010). Furthermore, such conditions as personal values related to sex, professionalism and the role of supervision are also aspects of clinical approaches to sex that have been explored (McConnell, 1976; Miller & Byers, 2011; Pillai-Friedman et al., 2014; Reissing & Giulio, 2010; Wiederman & Sansone, 1999). However, I have not yet come across literature exploring the

role of parenthood and having a catalyst or mentor as potential contributors to clinical sexual confidence.

**Counselor education.** Counseling programs already strive to include a vast amount of information into coursework. Whenever possible, an elective course reviewing sexuality counseling by a faculty with an expertise in the area would be ideal to address the training gap identified by participants in this study. If not feasible, sexuality can also be addressed within a variety of core coursework for counseling students. For example, instructors can be intentional about addressing sexual desire and arousal in ethics coursework with an emphasis on confronting sexual values and biases. Sexual development can be integrated into content about lifespan beyond the impact of puberty. Gender exploration by children and the shifting of sexual drives in older adults can also be thoughtfully presented by faculty instructors. The diversity of sexual experiences and oppression based on sexual orientation and sexual practices can likewise be included in coursework about social justice and multicultural approaches to counseling. Counselor educators should have a base knowledge of relevant and useful non-academic books or resources to offer students to continue expanding their comfort level and knowledge base related to client sexuality.

Supervisors in training would benefit not only from education about how to guide supervisees through their own or clients' sexual content or attraction in the therapeutic relationship, but also the possible sexual attraction that can arise in the supervisor/supervisee relationship. Regardless, educators themselves require a level of comfort with the topic of sexuality in order to move away from the shame that often shrouds the subject. Whenever possible, educational opportunities to enhance clinical and educational expansion about sexuality would strengthen the profession as a whole.

The information from these two stories through my own perspective offers support to the previous research calling for improvements in counselors' ability to work with sexual concerns with clients. Gray et al. (1989) addressed the need for counselor training programs to integrate didactic, skill-based, and personal-value exploration of human sexuality. Based on what these participants shared with me, it seems a combination of receiving information regarding sexuality, having opportunities to build self-trust, exploring personal values related to sex, and exposing themselves in safe environments to sexual content that may feel "taboo" or "private" would have a positive impact on their clinical abilities.

**Research.** Further qualitative research with more participants and varied voices would be extremely valuable to better contextualize how counselors encounter client sexuality. Future researchers could examine the correlation between parenthood as a motivator to become more comfortable talking about sexuality as identified in this research. Narratives from counselor educators and supervisors would also

be a relevant area of inquiry. As the participants here acknowledged, there has been a gap in their education; finding out more about the role of teachers and supervisors can shed light on opportunities to strengthen how the field approaches client sexuality. Content regarding sex may be less critical to counselor comfort; the ability to practice the process and reflect on personal sexual biases may be more impactful for clients and counselors alike. One voice that is presently lacking in this research arena is that of clients. Hearing directly from counseling clients and their reports of how their own clinicians have addressed or avoided the topic of sex would be a critical addition to our understanding of the role of sexuality in mental health counseling.

**Clinical implications.** Ultimately, counselors, supervisors, educators, researchers, and clients can all likely agree that barriers preventing counselors from engaging with sexuality as a therapeutic topic must be removed in order to best serve holistic client wellness. The participants in this study acknowledged some client relationships that have been impacted by the topic of sexuality. By utilizing research to improve training and supervision related to client sexuality, clients will have a higher likelihood of working with a counselor who can ethically, comfortably, and openly facilitate sexual wellness. The current study is a preliminary identification of some of the ways in which counselors experience client sexuality, but it is clear that more can and should be done within the counseling profession regarding sexuality.

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