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Letter from the Editors
Robert J. Zeglin & Jason Patton
1-2. This issue is the inaugural issue of the Journal of Counseling Sexology & Sexual Wellness: Research, Practice, and Education (JCSSW), the official journal of the Association of Counseling Sexology & Sexual Wellness. We are very excited about this new resource in the counseling field that is dedicated to advancing the research related to human sexuality and sexual wellness, especially as it concerns the work of counselors and other helping professionals. This letter from the editors is designed to welcome readers to the journal, share a bit of the history of the journal, and to thank the many people and organizations that made JCSSW happen.

"It's Happiness and Relief and Release": Exploring Masturbation Among Bisexual and Queer Women
Carolyn Meiller & Candice N. Hargons
3-13. Researchers have argued that masturbation contributes to sexual health, yet historically, masturbation has been stigmatized (Coleman, 2003). Only a handful of qualitative studies have investigated masturbation (e.g., Fahs & Frank, 2014), and none of these studies have specifically examined queer women’s masturbation. In the current study, ten bisexual and queer women (age 19-48; 4 Black, 6 White) were interviewed about their masturbation. Using thematic analysis (Braun & Clarke, 2006), six themes were identified: a) reasons for masturbating, b) politics of pornography, c) use of sex toys, d) feelings after masturbation, e) promoting masturbation, and f) silence around masturbation. Implications for sexual health and counseling are discussed.

Counseling the Kink Community: What Clinicians Need to Know
Stephanie M. Yates & Anita A. Neuer-Colburn
14-22. Recent media portrayals of Kink are prevalent, but not always culturally accurate and can perpetuate a stigma that impacts the therapeutic environment when working with Kink-oriented individuals. Misunderstanding the culture can increase prejudice, misdiagnosis, and maltreatment of Kink-oriented clients. The authors provide readers with an introductory primer on language used within the Kink culture, avoiding the pathology of cultural and personal preferences, and myths associated with Kink community practices. Implications for best practices are offered.

Consensual Qualitative Research of LGB Persons’ Counseling Experiences Addressing Religious/Spiritual Foci
Kristopher M. Goodrich & Melissa Luke
23-35. This article reports a Consensual Qualitative Research (CQR) analysis of the experiences of 12 participants who identified as LGB and received counseling that addressed religious/spiritual foci. Participants identified two primary and intersecting themes including an increased sense of agency and locus of control, as well as increased cognitive flexibility. Additional subthemes included manifestation of agency and locus of control intrapersonally, interpersonally, and globally. Subthemes of cognitive flexibility were also identified intrapersonally, interpersonally, and globally. Implications are discussed for counseling, counselor education, and future research.

A Population at Risk: Counseling Sexual Minorities with a Serious Mental Illness
Anthony Zazzarino & Corinne W. Bridges
36-47. Sexual minorities are at a greater risk for experiencing a serious mental illness (SMI) compared to heterosexuals, and sexual minorities suffering from a SMI experience stigma and discrimination that leads to a greater need for counseling services. Current research does not address the needs of sexual minorities with a SMI and how to prepare counselors to work with this population, as most sexual minorities with a SMI find that counseling services do not meet their unique needs. The purpose of this transcendental phenomenological study, grounded in a Husserlian philosophical and minority stress model conceptual framework, was to explore the experiences and perceptions of counselors who provide counseling services to sexual minorities with a SMI. Data were collected from six participants using semistructured interviews and followed a thematic data analysis process, ensuring thematic saturation. The results of this study highlighted many themes regarding the unique needs of sexual minorities with a SMI such as multiple minority stressors, negative counseling experiences, and the impact of family, as well as counselors’ perceptions regarding the lack of preparation in graduate school to work with sexual minorities with a SMI. Study findings may improve counselors’ understanding of the needs of sexual minorities with a SMI so they may provide more effective counseling services. This study also highlights the importance of training counselors to work with
this population and may support the efforts of counselor educators.

**LGBTQ* Responsive Sand Tray: Creative Arts and Counseling**
Melissa Luke & Harvey C. Peters

48-59. This article builds upon a heuristic framework for sand tray in supervision, multicultural focus areas, and the supervisory roles of teacher, consultant, and counselor to propose a framework for LGBTQ* responsive sand tray. This proposed framework provides supervisors with a creative arts-based structure to assist both counselors-in-training and practitioner supervisees in working with LGBTQ* persons, in a way that is culturally responsive and affirmative of their LGBTQ* identity. This article provides a group supervision case example and discussion to highlight the enactment and process of utilizing the proposed creative-arts framework.

**Too Taboo?: Preliminary Explorations of Counselor Experiences of Client Sexuality**
Molly R. Wilson

60-68. 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.

**Submissions**

If you are interested in submitting your work to JCSSW for consideration for publication, you can locate our submission requirements at https://digitalcommons.unf.edu/jcssw/styleguide.html. The JCSSW editorial team is committed to ensuring an efficient review process and aims to communicate all initial decisions within 90 days of submission. Please also feel free to contact Robert J. Zeglin (Editor) or “Jayce” Patton (Associate Editor) with any questions.
Letter from the Editors

Robert J. Zeglin
University of North Florida

Jason "Jayce" Patton
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This issue is the inaugural issue of the *Journal of Counseling Sexology & Sexual Wellness: Research, Practice, and Education (JCSSW)*, the official journal of the Association of Counseling Sexology & Sexual Wellness. We are very excited about this new resource in the counseling field that is dedicated to advancing the research related to human sexuality and sexual wellness, especially as it concerns the work of counselors and other helping professionals. This letter from the editors is designed to welcome readers to the journal, share a bit of the history of the journal, and to thank the many people and organizations that made JCSSW happen.

Welcome

Thank you, reader, for opening the pages of the inaugural issue of the *Journal of Counseling Sexology & Sexual Wellness: Research, Practice, and Education (JCSSW)*. JCSSW focuses on all domains of sexuality and counseling sexology including sexual identity, pleasure, gender issues, sexual health, theories of sexology, and sexual exploitation issues relevant to counselors, counseling educators, and counseling supervisors. It is the first and only peer-reviewed journal with this goal and for this audience.

JCSSW, as the official journal of the Association of Counseling Sexology & Sexual Wellness, defines "sexuality" broadly. We endorse the World Health Organization (2006, p. 5) definition of "sexuality" as:

> a central aspect of being human throughout life 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.

As a result, JCSSW acknowledges that sexuality intersects with a vast array of life domains and publishes articles framed within any of them. We use the Circles of Sexuality model (Corinna, 2011; Dailey, 1987) to operationalize how we consider whether content is related to sexuality. The Circles of Sexuality are: (a) intimacy, (b) sensuality, (d) sexual health, (e) sexual identity, and (f) sexual behavior and practices. We also consider whether the content is related to sexual rights, as defined by the World Association for Sexual Health in their "Declaration of Sexual Rights" (2014). You will see these priorities highlighted in our Aims and Scope:

The *Journal of Counseling Sexology & Sexual Wellness: Research, Practice, and Education* is a national peer-reviewed journal seeking to promote sexual wellness in the clients and communities counselors serve through a positive approach to sexuality and sexual rights. The journal publishes empirical research using rigorous quantitative and qualitative methods, best practices, descriptive and critical theory analyses, case studies, and current trends and issues focused on sexual wellness at all stages of life. Manuscripts should be of interest to professional counselors including clinical mental health, school, rehabilitation, and addictions counselors as well as to other helping professionals who work in a variety of mental and sexual health settings.

JCSSW is dedicated to publishing high-quality, medically accurate, sex positive, and non-stigmatizing sexuality-related content for counselors and other helping professionals. All submission to JCSSW undergo double-blind peer-review by at least two members of our Editorial Board, a talented and diverse group of professionals from across disciplines and specialties.

We thank you, the reader, for being a part of the expanding understanding of sexuality as part of the human experience and of overall wellness. We hope that you find the articles published in JCSSW helpful to you in your practice, research, teaching, and mentoring.

History of JCSSW

The study of sex and sexual wellness has an interesting and colorful past. Many are aware of the works of Magnus Hirschfield, affectionately known as the "Einstein of Sex," or
the detailed research of William Masters and Virginia Johnson, culminating in a stage model of sexual arousal. These pioneers of sexuality research advanced our knowledge, but they were also met with hostility and controversy. The latter team went on to perform Conversion Therapy, now almost universally considered detrimental to the mental health of those who endure it. Perhaps such incidents have served as implicit barriers to the research, or perhaps there is yet stigma within the academic community about the import and appropriateness of such work. Until recently, the counseling field has largely been devoid of research related to sex and sexual wellness, though we often acknowledge we must be prepared to address such content in our work.

In an effort to address this identified need, Dr. Wynn Dupkoski formed the Sexual Wellness in Counseling (SWIC) interest network in 2013 (Rudow, 2013). As membership and interest grew, several counselors attending the 2017 Association for Counselor Education and Supervision annual conference recognized the opportunity to expand the conversation about sexual health and wellness within the counseling field, particularly as it relates to counselor education and training. Over the course of just a year, these counselors, and many members of SWIC, formed the Association of Counseling Sexology & Sexual Wellness (ACSSW). ACSSW’s mission is to:

- promote sexuality as a central aspect of being human that includes the intersection of interpersonal and intrapersonal influences on sexual expression and identities inclusive of age, race, ethnicity, religion, sex, gender and gender expression, physical and mental health and abilities, and socioeconomic status.

Among many of the efforts to achieve this mission, ACSSW leadership ventured to create the first journal specifically dedicated to sexuality-related issues in counseling. As a result of their vision and dedication, we are now able to publish the first issue of The Journal of Counseling Sexology & Sexual Wellness: Research, Practice, and Education. We could not be more honored to have worked with and received the support of the ACSSW leadership, led by Dr. Angela Schubert, President of ACSSW. As the editors of ACSSW’s official journal, we acknowledge and appreciate the tremendous faith they have placed in us to steward the journal during its establishment and launch. We look forward to publishing many more issues of JCSSW and to continue being a part of the wonderful work being done by ACSSW.

Thank You

The JCSSW would not be possible without the generous contributions from our supporters including The UNF LGBT Resource Center, The UNF Writing Center, Melinda Rojas, and The UNF Thomas G. Carpenter Library. We thank you for being an integral part of the launch of this important journal and resource.

We would also like to thank our talented and supportive inaugural Editorial Board; all of their efforts will help us to inform the counseling profession of how to best serve our clients. Our Editorial Board is comprised of a diverse group of experts from across disciplines, specialties, and careers. Without their assistance and courage in light of the potential stigma surrounding sexuality research, we would not have been able to successfully launch this journal. Thank you for the keen eyes, thoughtful feedback, and experienced wisdom.

Finally, we want to thank the authors who contributed their work to our inaugural issue. We know that, in today’s academic climate, there is considerable pressure to publish in certain journals. Submitting your important work to a new journal shows tremendous passion and dedication to the field of counseling sexology, and highlights the need for exactly this type of quality outlet for such research. We thank you for being the stars of this inaugural issue of JCSSW.

References


It’s Happiness and Relief and Release”: Exploring Masturbation Among Bisexual and Queer Women

Carolyn Meiller
University of Kentucky
Candice N. Hargons
University of Kentucky

Researchers have argued that masturbation contributes to sexual health, yet historically, masturbation has been stigmatized (Coleman, 2003). Only a handful of qualitative studies have investigated masturbation (e.g., Fahs & Frank, 2014), and none of these studies have specifically examined queer women’s masturbation. In the current study, ten bisexual and queer women (age 19-48; 4 Black, 6 White) were interviewed about their masturbation. Using thematic analysis (Braun & Clarke, 2006), six themes were identified: a) reasons for masturbating, b) politics of pornography, c) use of sex toys, d) feelings after masturbation, e) promoting masturbation, and f) silence around masturbation. Implications for sexual health and counseling are discussed.

Keywords: masturbation, sexual health, bisexual, queer, qualitative

Introduction

Researchers have argued that masturbation, or self-stimulation of genitals for sexual pleasure, is a natural and beneficial aspect of sexual health (Coleman, 2003; Kaestle & Allen, 2011). However, masturbation is often stigmatized and seen as a taboo topic (Kaestle & Allen, 2011; Watson & McKee, 2013). The majority of the limited body of masturbation research has focused on straight White perspectives of masturbation (e.g., Kaestle & Allen, 2011). Although some studies examine the masturbation experiences of queer and bisexual women when looking at sexual pleasure as a whole (Goldey, Posh, Bell, & van Anders, 2016) or look at women’s masturbation broadly (Bowman, 2014), no studies have looked exclusively at the masturbation experiences of bisexual and queer women.

An understanding of the range of experiences bisexual and queer women have with masturbation may help to decrease the stigma and taboo associated with queer sexuality and masturbation. Furthermore, understanding the experiences bisexual and queer women have with masturbation and their sexuality can help mental health professionals address concerns related to sexuality with their clients. Moreover, research highlighting and normalizing the experiences people have with masturbation may help to undermine the stigma attached to masturbation, and may help to promote sexual health (Coleman, 2003). Using a qualitative approach, this exploratory study examined the experiences with and attitudes towards masturbation in 10 bisexual and queer women.

Masturbation as a Taboo

Historically, masturbation has been a stigmatized behavior, especially for women (Coleman, 2003; Tiefer, 1998). Religious, cultural, and medical values and practices have shaped historical views of masturbation as immoral, wrong, and leading to serious mental and physical health problems as early as the Eighteenth century (Lidster & Horsburgh, 1994). As masturbation, along with other expressions of sexuality, such as anal sex and sex for pleasure, broke the societal norm of sex for reproduction, these sexual expressions were often viewed as deviant (Mosher, 2017). Not until Kinsey’s research in the 1950s did masturbation begin to be seen as a common sexual practice among people (Kinsey, Pomeroy, & Martin, 1998). Continued research on masturbation and other expressions of sexuality that do not follow the traditional script of sex for reproduction can contribute to destigmatizing diverse expressions of sexuality.

The long history of stigma and association of masturbation with negative outcomes has been reflected in the extant literature. Research has found associations between masturbation and negative outcomes, such as depression (Brody & Nicholson, 2013; Frohlich & Meston, 2002) and guilt (Bowman, 2014; Carvalheira & Leal, 2013). Bowman (2014) and Carvalheira and Leal (2013) found that women commonly reported shame or guilt as an emotional
reaction to their masturbation, resulting in a decreased likelihood of positive physical and psychological outcomes associated with masturbation (Davidson & Darling, 1993). As masturbation is stigmatized by society, the guilt that results may be from the internalization of these messages, as opposed to the actual act of masturbation (Coleman, 2003).

Although many cultural values no longer equate masturbation with pathology, the stigma around masturbation remains today. Recent research has found girls begin to learn about negative societal views towards masturbation at young ages. In focus groups with girls between the ages of 14 and 16, Watson and McKee (2013) discovered young girls already knew about the taboo surrounding women’s masturbation. The girls in these focus groups reported more embarrassment speaking to their parents about masturbation than about sex. Additionally, the girls reported a lack of information about masturbation, due to lack of discussion or portrayal of women’s masturbation compared to men’s masturbation in school, among peers, or in the media. Madanikia, Bartholomew and Cytrynbaum (2013) confirmed this perception through a qualitative analysis of movies released from 2005-2010. Masturbators were most commonly portrayed as men (75%), White (77%), and heterosexual (82%), and often portrayed in a negative light. This research shows that women have internalized societal messages around masturbation at early ages, which may lead to guilt and shame seen in other studies. Furthermore, counselors and other mental health professionals are likely to have internalized similar beliefs about masturbation and hold biases related to sexuality and identity which can impact their work with clients (Cruz, Greenwald, & Sandil, 2017). Because of the long history of masturbation as a stigmatized behavior, it is important to balance the current research and also understand the positive and enhancing aspects of masturbation (Mosher, 2017).

Positive experiences with masturbation. Although some women report guilt and shame associated with their masturbation, positive experiences, such as empowerment, are also connected to women’s masturbation (Bowman, 2014). Additionally, women who engaged in masturbation reported decreased difficulties in arousal and lowered sexual inhibition (Carvalheira & Leal, 2013). Furthermore, women who had an orgasm during masturbation reported greater sexual desire, higher self-esteem, greater marital and sexual satisfaction, and less time to sexual arousal than women who reported not having an orgasm during masturbation (Hurlbert & Whittaker, 1991).

Although previous research primarily used heterosexual samples, Bowman’s (2014) sample included 29.5% lesbian, bisexual, and queer (LBQ) women. Bowman (2014) found significant differences between LBQ women and heterosexual women. Specifically, LBQ women reported more positive attitudes towards their genitals, more often masturbating for release and sexual pleasure, having masturbated more recently, and higher levels of sexual-efficacy, or belief in one’s ability to navigate a sexual experience. Although Bowman (2014) did not run full analyses to investigate further differences between LBQ and heterosexual women in the sample, initial differences call for further exploration of queer women’s masturbation. By delving further to fully understand masturbation for LBQ women, we can begin to understand the unique and varied experiences of LBQ women’s masturbation.

Qualitative methodology and masturbation. Much of the research on masturbation has been quantitative in nature. Previous research on masturbation focused on addressing a few primary questions: who masturbates, how often, and do they feel guilty (Bowman, 2014; Coleman, 2003; Goldey et al., 2016). Coleman (2003) and Tiefer (1998) have called for research to move beyond focusing on frequency and prevalence of masturbation and to instead explicate the range of experiences of masturbation. By only addressing the basic frequency of masturbation as well as the negative outcomes related to masturbation, the current literature further contributes to the silence and stigmatization of masturbatory behaviors. Furthermore, by using primarily White and heterosexual samples, masturbation is further stigmatized for diverse groups.

As masturbation is a natural part of healthy sexual development, researchers have argued for the need to normalize masturbation (Coleman, 2003; Fahn & Frank, 2014). One way to normalize people’s experiences with masturbation is to understand the range of experiences. Qualitative research is an ideal methodology to help raise the voices of diverse individuals to express their varied experiences with masturbation (Cresswell & Poth, 2017). Furthermore, qualitative research is especially useful in answering questions related to describing and understanding meaning, as well as understanding what and how people experience phenomenon (Cresswell & Poth, 2017). Qualitative research can provide in-depth, nuanced, and varied understanding of the experiences of masturbation among sexual minority women.

In the handful of qualitative studies on women’s masturbation (Fahn & Frank, 2014; Goldey et al., 2016; Kaestle & Allen, 2011; Morin, Levesque, & Lavigne, 2017; Watson & McKee, 2013) only one specifically looked at differing experiences for LBQ women (Goldey et al., 2016). However, this study discussed experiences of sexual pleasure more broadly, investigating differences in masturbation and partnered pleasure.

This study sought to fill some of these gaps by exploring masturbation among sexual minority women, looking at both personal experiences with masturbation and views and attitudes towards masturbation. An exploratory qualitative investigation allows the lived experiences of bisexual and queer women to be highlighted and allows researchers to gain
understanding of the range of masturbation experiences for bisexual and queer women. Importantly, in addition to describing the way some participants self-identified, queer will also be used in this paper to refer to other sexual minority identities that women self-identified, such as demisexual and pansexual.

Methods

Recruitment and Participants

Initial recruitment occurred through contacting LGBTQ+(lesbian, gay, bisexual, transgender, and queer; the + indicates inclusion of other sexual minority identities) organizations at a large public southeastern university and in the surrounding community. Flyers recruiting for the study were posted throughout the university campus. Snowball methods of recruitment also occurred as participants shared information about the study with friends or posted to social media. Interested participants were instructed to contact the primary investigator.

After participants expressed interest in the study, the primary researcher conducted an initial eligibility screener. To be eligible, participants had to identify as a woman, identify as LBQ+ (lesbian, bisexual, and queer; the + indicates inclusion of other sexual minority identities), be over the age of 18, have masturbated at some point in their lives, and be willing to talk about their experiences while being audio recorded. Recruitment continued until themes reached saturation, meaning that later interviews added no new themes to the data (Charmaz, 2014).

A total of 10 individuals were interviewed for the current study. Participants ranged from 19-48 years old. Four participants identified as Black and six as White. Three participants identified as queer (one further identified as demisexual), six identified as bisexual, and one identified as pansexual. Although participants who identified as lesbian were eligible for participation, none agreed to participate. Nine of the participants identified as ciswomen, one participant identified as gender-queer but used feminine pronouns and additionally reported self-identification as a woman. Participants were assigned pseudonyms to protect their confidentiality (see Table 1 for pseudonyms and further demographic information).

Procedures

All procedures were approved by the university Institutional Review Board. After conducting the eligibility screener, the researcher and participant agreed on a time and place to conduct the interview. Individual, face-to-face interviews were conducted on the university campus. Interviews began with the researcher reading aloud the informed consent document and answering any questions or concerns. Upon giving consent, the interviewer followed a semi-structured interview protocol. All interviews were conducted by the primary researcher, audio recorded, and transcribed. Interviews lasted on average 70 minutes. Examples of interview questions included: “How do you identify?” “How do you think society views women’s masturbation?” “What are your views on women’s masturbation?” and “When you think of your own masturbation, what comes to mind? Can you set that scene for me?”

Table 1

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<td>Joan</td>
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Note. Participants were asked “How do you identify?”. Participants self-described with the above identifications. The researcher asked about additional social identities that were not mentioned.
Subjectivities Statement

I (primary investigator) identify as a White, bisexual, cisgender woman who is a current doctoral student in a counseling psychology doctoral program with research focused on sexual health and sexual experiences of diverse individuals. As someone who grew up with a lot of sex-negative messages and education, I came to this project hoping to highlight and normalize the various experiences of masturbation among lesbian, bisexual, and queer women. I hoped to find stories of guilt and shame. As a bisexual woman, I wanted to contribute more diverse perspectives and voices to the sexual literature. I hoped that emphasizing the range of experiences LBQ+ women have with masturbation would further help to normalize masturbation as a form of sexual expression.

The second author identifies as a Black, straight, cisgender woman who serves as the primary investigator’s research advisor. She studies Black sexuality and relationships, and she has provided sex positive sexual health trainings for universities and community members for eight years.

Data Analysis

Thematic analysis was used to identify and name themes that appeared across the interviews as outlined by the six-step process described by Braun and Clarke (2006). First, to become familiar with the data, audio recordings were transcribed and read by the primary investigator. Next, initial coding began using grounded theory methods (Charmaz, 2014) of line-by-line coding for action, meaning, and content. This style of coding allowed researchers to stay close to the data collected. Afterwards, initial codes were collapsed into possible themes, and all the data that reflected these codes were identified. Next, reviewing themes took place in two forms, comparing the themes to the overall data set to check that the data set was reflected in the themes, and looking at relationships across themes, which spurred the creation of subthemes. After this, the themes were named and further defined so that they were more specific and clear. Themes were removed if support for them was not found across interviews.

Through consultation with the second author, themes were further collapsed and expanded, until six primary themes were identified. Supporting data for each of the themes was gathered from the interviews to expand the themes and identify sub-themes. The final step of the six-step method outlined by Braun and Clarke (2006) involved producing the report, which consisted of choosing the specific quotes that highlight each code best and connecting the information to past literature and original research question. Throughout this process, the primary investigator engaged in memoing (Charmaz, 2014) through writing down ideas and possible themes, as well as noting and processing reactions and biases.

Underlying these methods, a constructivist paradigm framed this research (Ponterotto, 2005). Under this paradigm, reality is constructed by the research participant, and therefore what they share in an interview inherently holds their experience and meaning making of the content expressed. In addition, the interactive nature of the interview means the researcher helps the participant engage in deep reflection to stimulate this deeper meaning making. Within this paradigm, the results in this research are a co-construction between researchers and participants.

Results

Results included six primary themes related to how participants experienced masturbation and saw masturbation within society. The following themes occurred in the interviews: 1) Reasons for Masturbating, 2) Politics of Pornography, 3) Use of Sex Toys, 4) Feelings after Masturbation, 5) Promoting Masturbation, 6) Silence around Masturbation.

Reasons for Masturbating

All participants endorsed a variety of reasons for masturbating. The following subthemes occurred: 1) Being in the Mood, 2) Improving Health, 3) Feeling Bored, and 4) Building Skills.

Being in the mood. Participants expressed masturbating because they were in the mood. As Daphne described, she masturbates “Just when I get horny in general.” For the women, being horny or turned on came from a variety of sources, such as movies, music, stories, and art. For example, Joan found spending time on the internet may lead to being in the mood. She described “getting turned on from reading a dirty story or running across a particularly nice piece of erotic art online, or just plain smut art.” For the interviewed women, outside sources that sparked the desire to masturbate were purposefully sought out or randomly found. Ella summed up the view of being in the mood as a need, “Like if you’re hungry you eat, if you’re thirsty you drink something, if you’re horny then you masturbate.” This quote equates desire for sexual pleasure as a naturally occurring need that manifests for most people in similar ways to thirst and hunger. Being in the mood in this view is a drive that might be brought on by environmental situations, but also may occur without prompting, and can be satisfied through masturbation.

Improving health. Masturbation was used by the women as both physical and mental health treatment. For Hannah, when something feels wrong with her body, such as a headache, one of her first attempts at treatment is masturbation, “for just like general health treatment.” Using masturbation to combat mental health difficulties such as stress was also described. For Joan, when she was in school, masturbation was a stress release. She stated, “I had a shitty day

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Thematic analysis was used to identify and name themes that appeared across the interviews as outlined by the six-step process described by Braun and Clarke (2006). First, to become familiar with the data, audio recordings were transcribed and read by the primary investigator. Next, initial coding began using grounded theory methods (Charmaz, 2014) of line-by-line coding for action, meaning, and content. This style of coding allowed researchers to stay close to the data collected. Afterwards, initial codes were collapsed into possible themes, and all the data that reflected these codes were identified. Next, reviewing themes took place in two forms, comparing the themes to the overall data set to check that the data set was reflected in the themes, and looking at relationships across themes, which spurred the creation of subthemes. After this, the themes were named and further defined so that they were more specific and clear. Themes were removed if support for them was not found across interviews.

Through consultation with the second author, themes were further collapsed and expanded, until six primary themes were identified. Supporting data for each of the themes was gathered from the interviews to expand the themes and identify sub-themes. The final step of the six-step method outlined by Braun and Clarke (2006) involved producing the report, which consisted of choosing the specific quotes that highlight each code best and connecting the information to past literature and original research question. Throughout this process, the primary investigator engaged in memoing (Charmaz, 2014) through writing down ideas and possible themes, as well as noting and processing reactions and biases.

Underlying these methods, a constructivist paradigm framed this research (Ponterotto, 2005). Under this paradigm, reality is constructed by the research participant, and therefore what they share in an interview inherently holds their experience and meaning making of the content expressed. In addition, the interactive nature of the interview means the researcher helps the participant engage in deep reflection to stimulate this deeper meaning making. Within this paradigm, the results in this research are a co-construction between researchers and participants.

Reasons for Masturbating

All participants endorsed a variety of reasons for masturbation. The following subthemes occurred: 1) Being in the Mood, 2) Improving Health, 3) Feeling Bored, and 4) Building Skills.

Being in the mood. Participants expressed masturbating because they were in the mood. As Daphne described, she masturbates “Just when I get horny in general.” For the women, being horny or turned on came from a variety of sources, such as movies, music, stories, and art. For example, Joan found spending time on the internet may lead to being in the mood. She described “getting turned on from reading a dirty story or running across a particularly nice piece of erotic art online, or just plain smut art.” For the interviewed women, outside sources that sparked the desire to masturbate were purposefully sought out or randomly found. Ella summed up the view of being in the mood as a need, “Like if you’re hungry you eat, if you’re thirsty you drink something, if you’re horny then you masturbate.” This quote equates desire for sexual pleasure as a naturally occurring need that manifests for most people in similar ways to thirst and hunger. Being in the mood in this view is a drive that might be brought on by environmental situations, but also may occur without prompting, and can be satisfied through masturbation.

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at school, or tests were bad or whatever, and I’d go home and masturbate.” In these ways, masturbation sometimes did not come about for women to satisfy an urge or a need to pleasure themselves, but instead came as a way to take care of themselves, physically and mentally.

**Feeling bored.** Most commonly, the women discussed masturbation coming from having nothing better to do. Masturbation was used by women to fill extra time. For example, Bianca described “like I’ve got an hour before my favorite show comes on, let’s go.” The women in this study also explicitly named boredom as a primary reason for masturbating. Felicia insisted “I feel like I only really do it if I’m bored.” A more common response involved describing another reason why they masturbated, such as being in the mood, and then also commenting that sometimes the reason was less clear and came from boredom.

**Building skills.** For these bisexual and queer women, masturbation offered an opportunity to practice and build skills that could be used to provide pleasure to women partners in the present or future. As Gloria summarized, “when you’re a queer woman you want to build your skills up a little bit.” Ingrid expanded on this statement by detailing the need to be comfortable with your own body as a woman in order to provide pleasure to other women. She said, “Besides it does help with your sexuality as well, and being comfortable enough as you are a woman, being comfortable with other women.” For the bisexual and queer women interviewed, masturbation provided a way to build comfort and skills with their own female bodies and genitals, which may later transfer to sexual relationships with other women.

**Politics of Pornography.**

Although the interview protocol did not ask about the use of pornography, pornography came up as related to the interviewed women’s experiences of masturbation in nine of the ten interviews. The women described specific approaches towards pornography, which included reconciling the desire to utilize porn, while also recognizing the harm of porn. Politics of Pornography took three forms, which made the following subthemes: 1) Seeking Representation, 2) Having Mixed Feelings Towards Porn, and 3) Seeking Specific Attributes in Porn.

**Seeking representation.** Seeing actors within pornography that reflected their own social identities was a priority for the women, specifically the six women who identified as Black and/or fat. Abbey specifically discussed searching for pornography of larger women of color who looked like her. She stated, “It makes me even more comfortable with my body. Seeing someone who’s shaped like me masturbating.” Women discussed not only becoming more comfortable upon seeing representation of themselves in porn, but also enjoying the porn more because they were better able to imagine the scenes as reality for themselves. Bianca, a Black woman who self-identified as fat, shared, “It really hard, especially as a woman of color to be consuming pornography of color, like I don’t have blonde hair. I don’t have a Pilates body.”

For Bianca, seeing other larger women of color masturbating also helped her feel more comfortable with her body, which allowed her to experience greater pleasure while masturbating.

**Having mixed feelings towards porn.** Participants reflected on the negative ways porn has treated their identities, specifically as bisexual and queer women. Participants struggled with how to enjoy and feel comfortable in their use of porn during their masturbation, while understanding the larger societal impacts of the messages within porn. Joan shared:

> I think there’s a real big stigma for women, much less queer women to look at porn, you know? It’s demeaning to women, it’s only made for men, especially if you’re a queer woman, you hear that one a lot.

Joan went on to describe how she has started giving herself permission to look at porn and go against some of these messages. Gloria experienced guilt for looking at porn because “porn really informs a lot of straight people’s ideas about gay and lesbian sex, and I feel guilty for looking it up and getting off on it.” The conflicted feelings towards porn would result in feelings of guilt or decreased pleasure during masturbation for the women interviewed. However, some women found ways to use porn that matched their values while masturbating, ultimately increasing their pleasure and experience of masturbation. For example, Bianca noted “sometimes a masturbation endeavor will turn into like an hour to two hours, because I’m still trying to find that video that I can just be okay with and continue on with the act.”

Bianca’s approach to pornography allows her to enjoy her masturbation to pornography, but also means she has to put more time and effort into finding pornography to utilize that matches her values.

**Seeking specific attributes in porn.** Outside of looking for porn that will align with their beliefs, women also had certain preferences in their porn, looking for their turn-ons, kinks, and quality. The search for the right porn became a guiding principle for these participants. For example, Ingrid searched for porn that feels genuine and described, “I want them to be like enjoying it or making it seem like they enjoy it, or like to actually see the vagina get wet.” For Daphne, the porn she looks at changes based on what stage of masturbation she is in. She details her journey of masturbating with porn as, “I start out looking at men and women first, and then I’ll go when I want to masturbate and might actually cum, I’ll look at lesbian porn.” In addition to looking for representation of their identities in pornography that mapped onto their values, participants also wanted quality porn that
aligned with what they found attractive, desirable, and sexy in order to enhance their pleasure while masturbating.

Use of Sex Toys

All ten participants described their views and use (or sometimes non-use) of sex toys in their masturbation. With sex toys, the women emphasized clitoral stimulation over penetration. Three participants discussed using toys to penetrate for a “filling” sensation but still emphasized clitoral stimulation, usually with a vibrator. When asked what comes to mind when thinking of their own masturbation, sex toys took center stage for the majority of women, such as Bianca who stated “batteries.” However, for two women, toys were overstimulating. Gloria explained, “I don’t really like toys. I guess I’m just very sensitive, so I always have felt overstimulated with vibrators.” In the use of sex toys, sexual orientation was centralized for three of the participants. Although she does not use toys herself, Gloria wanted queer women to feel like they could use toys without invalidating their sexuality. Gloria stated, “I really feel like because queer women do use toys with themselves and each other, that to the status quo that kind of validates this idea that secretly all women just really want a dick.” For Gloria, the messages have been that queer women’s use of sex toys undermines their queer identity. Although sex toys were related to all the interviewed women’s masturbation, the role the toys played varied. Sex toys were often used to increase pleasure during masturbation. However, experiences of overstimulation and connection of sex toys to stereotypes about the invalidity of their sexual orientation kept women like Gloria from being able to enjoy sex toys during their masturbation.

Feelings After Masturbation

Similar to the theme of reasons for masturbation, there was a range of feelings the women experienced after masturbation. The following subthemes were within feelings after masturbation: 1) Satisfaction, 2) Guilt and Shame, and 3) Frustration.

**Satisfaction.** Most commonly, eight of the ten women reported feelings of satisfaction after masturbation. Satisfaction included experiences of pleasure, happiness, relaxation, and release. Abbey embodied this feeling with a big sigh marked by satisfaction and feeling content. Bianca described the feeling of when masturbation is satisfying as “it’s almost like drinking enough water for the day.” Pleasure came up as another form of satisfaction. Ingrid described, “mostly it’s like pleasure, almost like loving myself...Feeling really connected with your own body.” Joan noted that she has varied feelings, but most often satisfaction: “it’s run the gambit, but mostly it’s happiness and relief and release.” Although the exact definition of satisfaction differed for the interviewed women, satisfaction was the most common feeling the women reported following masturbation.

**Guilt and shame.** Despite the women proclaiming primarily positive feelings and personal attitudes towards masturbation, feelings of guilt and shame were still present for four of the women. Women discussed feeling larger amounts of guilt and shame in the past. Hannah described feelings of “deep guilt” following orgasm from masturbation when she was younger. Gloria echoed these past experiences and discussed how sometimes she still feels similarly, “Some of that weird residual guilt and shame is still in there somewhere.” Although Gloria has other positive feelings about her masturbation now, old messages and understandings of masturbation sometimes lead to feelings of guilt and shame. Hannah emphasized no longer experiencing these same residual feelings. She explained, “The best part about afterwards now is that I don’t have any of the shame and guilt. . . I feel this strong sense of relief for not feeling shame and guilt.” The experiences of Hannah and Gloria highlight the lasting impact negative messages about masturbation had on their experiences with masturbation later in their lives.

Ingrid expressed feelings of shame following her masturbation related to the material that enhanced her masturbation. She stated, “The after part, it’s always like that brief period of shame, it’s like oh my god I can’t believe I read that type of stuff, or I watched that.” Therefore, guilt and shame were not always directly related to engaging in the act of masturbation but sometimes related to material used during masturbation, similar to the Politics of Pornography theme.

**Frustration.** For half of the participants, frustration was associated with not being satisfied or pleased through masturbation. Frustration occurred when masturbation was taking too long to reach orgasm and finding the right supporting material was proving difficult. Ingrid described feeling “frustration if I can’t find the right clip or read the right thing.” Frustration in this way was attached to being unsatisfied in the material she was hoping to use to enhance her masturbation experience. Joan lamented the fact that sometimes she is unable to orgasm and has to go to bed frustrated. She stated, “Sometimes I’ve just gotten flat out angry at myself and stopped.” Frustration was connected to an inability to experience pleasure, such as through difficulty finding supporting materials, porn or erotica, to improve the moment or inability to climax.

Promoting Masturbation

Nine participants used the interview as a platform to promote masturbation by sharing their views of masturbation as a natural behavior and their desire for people to masturbate more. When asked about her own views on women’s masturbation, Abbey responded, “It should be done more!” Belief of masturbation as “totally normal and natural,” as expressed by Ella, was common. Participants cited many reasons for increasing masturbation frequency, such as physical health. The majority of the women expressed benefits of masturba-
tion in increasing comfort and knowledge about sex. Daphne expressed, “I feel like it’s something you need to do. You need to know what turns you on. You need to know what turns you off.” Within their promotion of masturbation, the women interviewed shared the viewpoint that masturbating was a necessary aspect of understanding and experiencing their sexuality.

Specifically, women wanted to promote discussion of masturbation as a form of sexual health. Joan asserted, “I think it’s a good and healthy thing, and we need to make sure people continue to understand that it’s a good and healthy thing.” Joan went on to specifically talk about how sexual minority women’s masturbation in particular “... needs to be spoken about and it needs to be destigmatized” and calls for education around masturbation as an alternative to partnered sex. The women interviewed discussed normalizing masturbation as a way to encourage more people to masturbate to improve their sexual health and pleasure.

Silence Around Masturbation

Women were asked how they thought society viewed women’s masturbation and specifically LBQ+ women’s masturbation. A common theme in eight of the interviews was silence around masturbation. Mostly, participants reflected on the non-discussion and non-acknowledgement of women’s masturbation. A distinction was made in how society actually views masturbation versus how it is implicitly or explicitly portrayed. Felicia described, “In the United States people mostly think it happens and mostly are okay with it, but nobody ever really talks about it.” The majority of women noted the specific silence society has in regard to women’s masturbation. Joan, for instance, stated “nobody really talks about it.” The majority of women interviewed noted the specific silence society has in regard to women’s masturbation. A distinction was made in how society actually views masturbation versus how it is implicitly or explicitly portrayed. Felicia described, “In the United States people mostly think it happens and mostly are okay with it, but nobody ever really talks about it.” The majority of women noted the specific silence society has in regard to women’s masturbation. Joan, for instance, stated “nobody really talks about it.” The majority of women interviewed noted the specific silence society has in regard to women’s masturbation. A distinction was made in how society actually views masturbation versus how it is implicitly or explicitly portrayed. Felicia described, “In the United States people mostly think it happens and mostly are okay with it, but nobody ever really talks about it.” The majority of women noted the specific silence society has in regard to women’s masturbation. Joan, for instance, stated “nobody really talks about it.”

More implicit messages around masturbation communicated to the participants that masturbation is something to be kept secret. Bianca described the ways masturbation is discussed and that “masturbation also gets this shh, don’t talk about it, allude to it. Use a weird metaphor that kind of makes sense.” The use of metaphors or need to discretely buy vibrators “in a little pink box”, as described by Joan, portrays the message that while masturbation is okay, it is not to be discussed or shared with others. A distinction was made between how society viewed men’s and women’s masturbation. Felicia shared that “[women’s masturbation] is accepted but maybe not something that you would just be talking about. Whereas boys’ masturbation I feel like now people just talk about now more, more than girls.” For Hannah, the discussion of men’s masturbation along with the silence around women’s masturbation made her think that masturbation was not for women. She described, “If I’d thought about it, I think I associated that word with dudes.” Although the majority of interviewed women felt bisexual and queer women’s masturbation was viewed similarly to heterosexual women’s masturbation by society, Joan shared a different view: “I don’t know if they have any idea what to do with queer women having sex, much less masturbation. Unless it’s lesbian porn for guys, I don’t think they have any idea.” From Joan’s perspective, perhaps the silence around queer and bisexual women’s masturbation is even more prevalent within society.

Gloria shared that the silence around masturbation in society led her to the conclusion that “you don’t ever know how you are supposed to feel about it.” However, for four women the silence meant masturbation was something that was wrong. For Felicia, the messages of silence meant hiding her vibrator. She disclosed, “When I was a teenager, I had a vibrator, and I always just hid it. It was always just obvious that I would want to put this where I put my cigarettes and stuff.” The implicit message behind hiding a vibrator with cigarettes is that masturbation and smoking under age are similar and need to be hidden in the same way. The dominant view the women perceived society as having towards women’s masturbation was silence and non-acknowledgement. However, this silence still affected the way they thought and felt about masturbation. As Abbey summarized, “It’s something that’s taught consciously as well as subconsciously. By not talking about it, you’re teaching something.” The silence around masturbation these women experienced within society directly contrasted with and bolstered their personal beliefs in the need to promote and normalize masturbation.

Discussion

This exploratory study focused on how bisexual and queer women experience and understand their own and societal attitudes towards masturbation. The thematic analysis highlighted common themes across their understandings. The results show the diverse and shared experiences among the 10 bisexual and queer women interviewed. Six themes were constructed: 1) Reasons for Masturbating, 2) Politics of Pornography, 3) Use of Sex Toys, 4) Feelings after Masturbation, 5) Promoting Masturbation, 6) Silence around Masturbation.

Although there were aspects of masturbation that the majority of women interviewed endorsed, such as use of toys, pornography, and emphasis on clitoral stimulation, there was still a great amount of variety in masturbation within this sample. Specifically, the women discussed a range of reasons for masturbating and feelings that came after masturbation. There was a range of these factors across women, but also for the individual woman. These results are similar to the Bowman (2014) study, in that the heterosexual and LBQ women in that study both reported a variety of feelings following masturbation and reasons for engaging in masturbation. Similar to Bowman’s (2014) study, bisexual and queer women in the current study reported pleasure, being in
the mood, and relieving stress as reasons for masturbation. Furthermore, feelings of shame following masturbation were found in both studies.

In contrast to the Bowman (2014) study, women in the current study did not discuss masturbating due to dissatisfaction with their sexual lives or as a substitute for partnered sex. In fact, the majority of the women talked about masturbation in addition to and complementing satisfactory sex with a partner. The focus on bisexual and queer women also allowed the themes to highlight specific aspects of masturbation influenced by sexual orientation and other intersecting identities. For example, both the women in Bowman’s sample (2014) and the current study discussed masturbation as a form of learning about one’s body. However, unique to the queer and bisexual women in this study was translating learning about one’s body to building skills to pleasure a partner. Research has shown that most sexual education programs within U.S. schools do not cover information related to LGBTQ+ individuals (Santelli et al., 2006). Due to lack of information in formal sexual education, LGBTQ+ individuals often turn to alternative sources of information related to sex and sexual health, such as the internet, pornography, and friends (Charest, Kleinplatz, & Lund, 2016; Estes, 2017). Perhaps, for bisexual and queer women, engaging in masturbation is another source of information to learn about sex with other women.

Additionally, the women interviewed discussed how stereotypes and perceptions of their sexuality influence their masturbation. For example, the women detailed how their use of sex toys led to others invalidating their sexuality. For some of the women, the use of sex toys had been linked to delegitimizing their sexual orientation and leading others to viewing them as heterosexual due to their use of phallic-shaped toys for penetration. This research complements the common stereotype that bisexuality is not a legitimate sexual orientation (Flanders, Robinson, Legge, & Tarasoff, 2016; Friedman et al., 2014; Matsick & Rubin, 2018). Researchers have argued that bisexual and non-monosexual individuals, or those who are attracted to more than one gender, experience greater amounts of stereotyping and discrimination based on double discrimination from heterosexism and monosexism (Flanders et al., 2016; Friedman et al., 2014; Matsick & Rubin, 2018). Stereotypes and perceptions of bisexual and queer women were additionally present in the ways women navigated and used pornography.

Women in this study searched for porn that did not stereotype or portray LBQ women for a heterosexual male audience. The difficulty the women in the current study expressed in navigating their values and their use of porn complements a larger systematic review of qualitative research on women’s experiences with porn (Ashton, McDonald, & Kirkman, 2018). For women who identified as Black and/or larger women, representation of these identities along with their sexual orientation within pornography was also a focus. Research has previously found that Black and Hispanic youth prefer pornography with actors of the same race as them (Rothman, Kaczmarsky, Burke, Jansen, & Baughman, 2014). However, this may also be problematic, as Black and Hispanic women have been found to be hypersexualized and stereotyped within porn (Miller-Young, 2010).

Underlying many of the themes in the current study is a tension between feeling silenced or stigmatized and moving towards breaking the taboo around masturbation. With the use of sex toys and pornography, the majority of the women in the study reported enjoying and using these resources to complement and improve their masturbation, while contending with external and internal stigma and guilt associated with their use. Feelings of guilt and shame following masturbation directly undermined feelings of satisfaction. And ultimately, societal silencing of masturbation taught the women interviewed to hide their masturbation as they strive to encourage others to masturbate and emphasize the positive elements of masturbation.

The interviews with the women underscore the need to normalize and discuss masturbation within society on a larger scale to help ease the tension between silence and breaking the taboo around masturbation. Research has previously supported the need to normalize masturbation (Coleman, 2003; Kaestle & Allen, 2011). Masturbation has been linked to less difficulty in sexual arousal (Carvalheira & Leal, 2013), greater sexual desire, higher self-esteem and greater sexual satisfaction (Hurlbert & Whittaker, 1991). However, even with the positive potential of masturbation, women reported silence as being the dominant societal message around women’s masturbation. Fahs and Frank (2014) discuss the impact of silence around masturbation by stating, “...the relative invisibility of women’s masturbation infects women’s consciousness about how they talk about, think about, and engage in masturbation” (p. 241). The invisibility around women’s masturbation may be a possible contributor to women having different perceptions of masturbation than men. For example, Kaestle and Allen (2011) found that whereas 62.5% of men in an undergraduate sample believed that masturbation was critical to sexual health, only 16.1% of women within the sample held this same belief.

More explicit reactions to masturbation within U.S. society enhance and reinforce the societal silence around masturbation. For example, Dr. Joycelyn Elders, the first African American Surgeon General of the United States was fired in 1994 for suggesting masturbation be taught in schools as an aspect of sexual health (Coleman, 2003). In this way, the United States sent a clear message that masturbation should not be discussed.
Limitations

This study originally set out to understand the experiences of LBQ+ women’s masturbation; however, a limitation to the study was that we did not have any lesbian participants. There are several reasons why this may have occurred. One possible reason is that the number of individuals who identify as bisexual is increasing faster than other LGBTQ+ identities (Copen, Chandra, & Febo-Vazquez, 2016). Furthermore, as masturbation is still a taboo topic, perhaps queer and bisexual women are more open to masturbation, and therefore more likely to respond to a research study about masturbation, than lesbian women. In fact, identifying as queer has been positively associated with empowerment and activism (Galinsky et al., 2013; Gray & Desmarais, 2014). Therefore, perhaps greater engagement in activism among queer individuals and increasing identification as bisexual led to the current sample.

While not satisfying the original goal of understanding LBQ women’s masturbation experiences, focusing on queer and bisexual identities allowed for a greater understanding of the unique aspects of masturbation for bisexual and queer women. Researchers have discussed how the experiences of bisexual individuals is often underrepresented within psychological research (Polliet et al., 2018), and especially bisexual people of color (Ghabrial & Ross, 2018). Many studies that mention bisexual along with gay and lesbian do not often focus on the unique experiences of bisexual individuals (Polliet et al., 2018). Furthermore, Israel (2018) argues for a need to focus on bisexuality within the field of psychology as a distinct identity and not subsumed within a larger LGBTQ+ framework. Therefore, the focus on bisexual and queer women in this study provides an important and previously unexamined perspective. However, future research should look into the experiences of lesbian women’s masturbation. Additionally, a limitation of this study is that all of the participants held primarily positive views towards masturbation and expressed genuine interest and excitement over the topic. In future research, it will be important to recruit participants with a greater diversity of opinions on masturbation.

Implications for Counseling

The results of this study show the varied and complex masturbation experiences and views of bisexual and queer women. The women described pleasure and passion related to their masturbation and masturbation more generally. However, they also shared difficulties related to stereotypes about their sexual orientations in connection with their sexuality and the general silence in society around women’s masturbation. Echoing Dr. Elders’ message, the women interviewed stressed the need to normalize masturbation. Psychologists and counselors are in a unique position to answer this call. Sexual health as defined by the World Health Organization (2006) includes mental and emotional well-being, as well as the possibility of the experience of pleasure. Mental health professionals can help clients address negative attitudes and emotional reactions towards sex, and specifically masturbation. Although the participants within this study held primarily positive views towards masturbation, they still at times felt negative emotions, such as guilt, or grappled with stereotypes about their sexual orientation. Bisexual and queer women who have more negative views towards masturbation might experience additional negative reactions to masturbation. Therapists can help clients work through negative views they hold about masturbation and work to help clients have more positive attitudes and beliefs about masturbation, which is important for overall sexual health promotion.

The participants within this study discussed the silence around women’s masturbation within society. Due to the stigma around masturbation (Coleman, 2003), people may feel hesitant to discuss difficulties around masturbation in a therapeutic context. Despite the prevalence of sexual concerns connected to mental health issues (Bolon, 2005), therapists report low rates of initiating conversations with clients about sexuality and sexual health (Miller & Byers, 2009). Therapists should actively work to decrease the silence around sexuality, and specifically masturbation, within their work with clients in order to normalize the variety of ways people engage in and experience sexuality through proactively bringing up sexuality and sexual health within therapy (Cruz et al., 2017).

Finally, therapists should be aware of their own biases about sexuality and masturbation, especially for bisexual and queer women. Cruz, et al. (2017) argue that therapists are just as likely as clients to have negative views about sex and sexuality. The bisexual and queer women within the present study noted some possible stereotypes and biases therapists may hold about sexual minority women’s sexuality and masturbation, including invalidation of bisexuality and stigmatized views of queer sexuality as influenced by media such as porn. Therefore, therapists need to spend time examining their own biases about sexuality, especially as related to marginalized identities (Cruz et al., 2017). Ultimately, the above study and previous research highlights positive aspects of masturbation for bisexual and queer women, such as increasing experiences of pleasure, comfort with one’s own body, and mental and physical self-care. Therefore, therapists should make sure they are prepared to discuss sexuality, including masturbation, with their clients to promote sexual and overall health and wellness.

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Counseling the Kink Community: What Clinicians Need to Know

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Recent media portrayals of Kink are prevalent, but not always culturally accurate and can perpetuate a stigma that impacts the therapeutic environment when working with Kink-oriented individuals. Misunderstanding the culture can increase prejudice, misdiagnosis, and maltreatment of Kink-oriented clients. The authors provide readers with an introductory primer on language used within the Kink culture, avoiding the pathology of cultural and personal preferences, and myths associated with Kink community practices. Implications for best practices are offered.

Keywords: kink, BDSM, cultural sensitivity

Introduction

In recent years, pop culture (music, films, and literature) exposure of alternative sexualities and lifestyles have increased, with particular attention being paid to the Kink community. Examples of this includes popular fiction novels such as "Fifty Shades of Grey" (James, 2011), films such as "The Secretary" (Fierberg, Hobby, & Shainberg, 2002), and songs such as “S&M” (Dean, Eriksen, Hermansen, & Wilhelm, 2010). Unfortunately, these portrayals are not always accurate and may contribute to increased negative stereotyping of a community still fighting for equal rights and protection. Kink is not a new concept and has been found in literature and artistic portrayals for centuries, dating as early as ancient texts to present day (Bolin & Whelehan, 2015). However, increased social awareness has brought this community and their practices into the forefront of media attention.

Perpetuated stigma has led to obstacles for members of the Kink community to obtain rights and protection within the judicial system in regard to child custody, discrimination, prejudice, and mistreatment (Lin, 2016). The stigma also interferes with obtaining culturally sensitive and evidence-based practices in the therapeutic setting, despite recent significant changes to the Diagnostic Statistical Manual-5 in 2013 (American Psychiatric Association, 2013; Wright, 2006). Early versions of the manual classified individuals within the Kink community as "deviant" or labeled kink practitioners as having a paraphilic disorder, contributing to the stigmatization of this population by professionals (Bezreh, Weinberg, & Edgar, 2012). It may be that a skewed or limited understanding of the population could be the cause.

While many professionals and experts have stated their definition of Kink, there is not currently an established and unanimously agreed upon definition for the kink community or its practices. The most recent definition of Kink in the Merriam-Webster Dictionary (2018) defines "Kink" as “unconventional sexual taste or behavior.” Experts within the Kink community such as Miller and Devon (1995) defined Kink as “sexual practices that go beyond what are considered conventional as a means of heightening the intimacy between sexual partners.” Other experts such as Taormino (2012) have defined Kink as a ‘term that covers BDSM, sadomasochism, kinky sex, dominance and submission, role play, sex games, fantasy, fetish, and other erotic expressions.” Popp and Kaldera (2014) define kink as “A general term for the practice of BDSM and/or a number of paraphilias, including but not limited to fetishistic cross-dressing, unusual sexual roleplaying, or sexual arousal from items other than a human body. However, most people who identify as ‘kinksters’ learned that term in the BDSM demographic and use it to describe those activities” (p. 6). Each of these definitions emphasizes the alternative sexuality of the lifestyle but does not do justice to the deeper contexts of the culture embedded in the community’s values, customs, and social normative behaviors.

The alternative sexual practices of the Kink community can often overshadow the fact that the community has its own set of belief systems, values, social norms, practices, ceremonies, organizations, customs, and ways of understanding (Moore, Pincus, & Rodemaker, 2018). The Kink community has art and emblems unique to these values as well as their own rituals and hierarchy (Jozifkova, 2013). Kink-
oriented individuals also have a unique set of terminology and language that they understand differently than individuals outside the community (Moore et al., 2018). To be effective helping professionals, counselors must understand that Kink is more than the sexual interactions prominently displayed and advertised by pop culture. Instead, Kink is actually a thriving culture based on acceptance, communication, trust, empowerment, and fulfillment.

Therefore, the purpose of this paper is to offer guidance and resources for clinicians working with individuals who identify as members of the Kink community. This resource will enable clinicians to reframe their understanding of Kink in order to treat individuals within this community based on cultural sensitivity and protect them from additional discrimination, prejudice, abuse, and residual effects of societal isolation. We will explore important subjects such as terms and language used within the Kink culture, avoiding the pathology of cultural and personal preferences, and myths associated with Kink community practices. Finally, we will offer best practices for clinicians providing services to members of the Kink community.

**Terms**

We define Kink as a culture or lifestyle outside of the social norm centered around consensual non-egalitarian relationship practices, concepts of monogamy, sexual interactions, sexual activities and/or fantasies as a means for heightened intimacy between partners. In contrast, groups and individuals who do not identify with BDSM as part of their identity are known as vanilla. This term will be used to define individuals who follow social norms in their relationship styles, sexual practices, and sexual activities. While it may seem there is a defined boundary, readers should keep in mind that the line between "Kink" and "vanilla" is arbitrary and spectral in that it depends on how an individual identifies (Taormino, 2012), much like the commonly known spectrum of sexuality. One can identify as "vanilla" while enjoying an occasional kink activity just as a heterosexual female may occasionally have intimate contact with other women but identify as "straight." Therefore, social norm in this context is to be understood as the nature of modern-day relationships in terms of non-stigmatized relationships and what is considered acceptable and/or appropriate behavior within dominant society. The term culture will also be understood as the belief systems and value orientations that influence customs, norms, practice, and social situations, including psychological processes and organizations (Sue & Sue, 2016).

**BDSM**

Merriam-Webster Dictionary (2018) inaccurately defines BDSM as “sexual activity involving such practices as the use of physical restraints, the granting and relinquishing of control, and the infliction of pain.” BDSM is actually, however, the overlapping acronym for bondage and discipline (BD – the use of physical or psychological restraints), dominance and submission (DS or D/s – active participation in the consensual and negotiated exchange or handing over of power or authority to another), sadism and masochism or sadomasochism (SM or S&M – engaging in activities that involve intense or strong sensation and/or stimuli) (Ambler et al., 2017; Jozifkova, 2013). Community members do not, however, necessarily take part in all of these components. Rather, members may participate or identify with any one or more of the components of BDSM at any given time (P. Miller & Devon, 1995). Those within the Kink community tend to understand that BDSM is a large part of identifying as Kink for the majority of members, and so the terms Kink and BDSM can be interchangeable as well as exclusive terms in community terminology (Taormino, 2012; Sagarin, Cutler, Cutler, Lawler-Sagarin, & Matuszewich, 2008). It is also commonplace for community members to have explicit and detailed discussion to ensure a safe and consensual relationship and/or interaction (Wiseman, 1996). Discussion is especially important since much of the practice of BDSM requires careful and cautious communication that includes what someone will or will not be interested or willing to participate in to identify hard limits (that which someone will absolutely not do) and soft limits (activities that are not preferred, but may be considered with the right partner(s) under the right circumstances; Klement, Sagarin, & Lee, 2016; Wiseman, 1996).

BDSM relationships can be strictly negotiated and specified with a determined end date/time, or long term with an ongoing dynamic. No matter the temporary or permanent nature of the relationship itself, activities are still typically conducted in a safe, negotiated space over a specific period (Williams, Thomas, Porter, & Christensen, 2014). Long, formal activity sessions where two or more people come together in a planned session to practice BDSM are known as scenes while the actual practice, use of tools, and use of skill related to BDSM activities conducted within the scene is known as play (Popp & Kaldera, 2014; Wiseman, 1996). It is also very important to note that playing and "scenes" do not always include sexual contact or interaction. BDSM interactions can be physical, emotional, psychological, spiritual, or any combination of these (P. Miller & Devon, 1995; Taormino, 2012; Wiseman, 1996).

Scenes and certain relationship styles often include an act that is termed a power exchange. Power exchange is the willful, consensual, and negotiated exchange of power or authority from one unit or person to the other(s) (Moore et al., 2018). The period following the scene or play time in which participants receive physical, emotional, and psychological care and debrief with their partner(s) is known as aftercare. This can manifest as cuddling and tenderness or as a water break with chocolate treats. No matter the manifestation,
there is a detailed discussion of how the scene was or was not successful as well as the reactions each participant experienced (Sagarin et al., 2008). Aftercare is not seen by the Kink community as optional, but rather as a duty and a responsibility of the top toward the bottom. In fact, one study identified that the average scene lasts 55 minutes while the average aftercare lasts 19 minutes, which is roughly one third of the time spent in the actual activity (Ambler et al., 2017). This support can correspond to the ethical responsibility of a clinician to follow up and support a client following a particularly intense therapeutic session.

The roles, in their basic forms, typically involve that of a Dominant (Dom/Domme), Submissive (sub), Service Top (Top), Service Bottom (bottom), and Switch (Popp & Kaldera, 2014; P. Miller & Devon, 1995; Taormino, 2012). The Dom/me exerts control over a submissive and may direct him/her/this to complete tasks, behave in a certain way, obey certain commands, or submit to various kinds of SM. The sub voluntarily, with explicit consent, surrenders control to the Dom/me, complies with the dominants wishes, follows orders, and finds fulfillment in pleasing, serving, and caring for the dominant. The role of a Top takes on a similar role as a Dom/me but is limited to a time period expressly for the purpose of scene and/or play. Similarly, a bottom takes on the role of a sub for a limited and negotiated time period but sheds the role when the scene/play concludes. A switch is an individual who takes on any of the aforementioned roles but may prefer certain roles over others. It is important to note that there are multiple sub-categories and sub-cultures within BDSM roles, relationships, and practices, too many to identify in one article. As with any culture or form of identity, labels and titles can change based on perception and how an individual identifies that role.

**Pathologizing vs. Pathology**

In response to recent advocacy movements benefiting alternative sexualities, the American Psychiatric Association (APA; 2013) updated the latest version of the "Diagnostic and Statistical Manual of Mental Disorders" to reflect the difference between paraphilic disorders and the culture of Kink. Diagnoses such as Voyeuristic Disorder, Exhibitionistic Disorder, Fetishistic Disorder, Sexual Sadism Disorder and Sexual Masochism Disorder were changed such that they must include criteria such as presence of distress exemplified by anxiety, guilt, shame, and obsessions surrounding the symptoms/behaviors that interfere with important areas of functioning in order to be diagnosable. Sexual Sadism Disorder, Voyeuristic Disorder, and Exhibitionistic Disorder also require the criterion of being enacted against another individual without their consent. Without the presence of these criteria, the APA (2013) states that individuals can be termed as having a "relatable sexual interest" but not as having a disorder (p. 685-686).

The practices of Kink community members hinge on one central construct: consent (Wiseman, 1996). Kink-oriented individuals adhere to strict values and belief systems to protect the community and its members. These cornerstones include radical honesty, candid communication, expressed consent, safety practices, trust, and full knowledge and disclosure of risk (Moore et al., 2018; Pitagora, 2013; Taormino, 2012; Tripodi, 2017; Wiseman, 1996). The Kink community adopted their own set of principles that represent the core values, which include consent, negotiation, safety and risk reduction, communication, and aftercare (Taormino, 2012). A common phrase to encompass these values within the Kink community is the motto of "Safe, Sane, and Consensual" (Williams et al., 2014). Of these values, the one of highest importance is that of consent (Jozífkova, 2013; Tripodi, 2017; Williams et al., 2014).

Consent is the hub of the belief system observed by Kink-oriented individuals. When in social situations, all interactions are candidly and carefully negotiated and not enacted until enthusiastic consent, defined as "an active collaboration for the benefit, well-being, and pleasure of all persons concerned" (Wiseman, 1996, p. 8) is received (Taormino, 2012; Tripodi, 2017; Wiseman, 1996). Consent starts in pre-negotiation when participants identify what activities they are willing to do, for how long, with whom, and in what way (Klement et al., 2016). If an activity or interest is not discussed and happily agreed upon, it is not an option for that period of time and interest should be brought up as an option for future scenes during aftercare. Consent is also not assumed throughout the negotiated interactions and steps are taken to assure that an individual or group of individuals are always able to halt or pause interactions through the use of safe words and/or safe gestures (Ambler et al., 2017; Jozífkova, 2013; Klement et al., 2016; Wiseman, 1996). The use of a safe word or safe gesture automatically removes consent and commands a halt to activities (Pitagora, 2013). Responsible practitioners will also consistently check in to garner further consent and reactions throughout all interactions (P. Miller & Devon, 1995; Taormino, 2012; Tripodi, 2017; Wiseman, 1996).

Another key difference between paraphilic pathology and Kink culture is in the motivation. Kink-oriented individuals will likely report that their motivation is not only to serve their sexual and relationship needs, but to fulfill their need for intimacy and closeness while meeting the same needs for their partner (Sagarin et al., 2008). Relationships within the Kink culture are heavily reliant on vulnerability and open, honest, communication. Kink practitioners are encouraged, and at times required, to discuss the depth of their feelings, fantasies, fetishes, desires, and longings (Klement et al., 2016). Those who participate in dominant and submissive play particularly engage in activities that build intense feelings of trust and accountability (Tripodi, 2017). Such
motivations and communication lead to strong feelings of intimacy and bonding (Sagarin et al., 2008). Therefore, if a client were to express sexual excitement over physically hurting or humiliating a nonconsenting person, psychopathology and abuse is likely present (Dunkley & Brotto, 2018).

**Debunking the Myths of Kink**

As with most cultures, one key to combating bias and prejudice is to understand and debunk the myths and stereotypes that surround Kink culture. The myths and stereotypes surrounding the culture and subcultures of the Kink community have greatly impacted its members (Wright, 2008b). Among these myths are common beliefs that Kink-oriented individuals are deviant or mentally ill, tend to be violent or emotionally unstable, perpetuate the subjugation of women, are unable to have stable and healthy relationships, and tend to be uneducated (Bezreh et al., 2012; Connolly, 2006; Cross & Matheson, 2006; Gemberling, Cramer, Wright, & Nobels, 2015; Klement et al., 2016; Lin, 2016; Wright, 2006). These myths have been perpetuated beyond social stigma into misguided practice by helping professionals (Bezreh et al., 2012; Connolly, 2006; Gemberling et al., 2015; Sandnabba, Santtila, Allison, & Nordling, 2002; Sprott, Randall, Davison, Cannon, & Witherspoon, 2017; Richters, Visser, Rissel, Gurlich, & Smith, 2008; Waldura, Arora, Randall, Farala, & Sprott, 2016; Wismeijer & van Assen, 2013; Wright, 2006).

A study conducted by the National Coalition for Sexual Freedom (2008) outlined the prevalence of discrimination and stigma against members of the Kink culture showing that approximately 49% of the 3,058 respondents reported discrimination by a medical professional, 39% reported discrimination by a mental health professional, and 25% by a police or government officer. The respondents also reported instances of loss of jobs and/or contracts (20%), refusal of service (19%), divorce or separation (13%), loss of promotion and/or demoted (12%), and loss of child custody (6%). In addition, findings revealed that 35% of respondents reported loss of friends, alienation, refusal of entertainment and celebration venue rental, refusal of use of public spaces, and denial of permits for peaceful protest or picketing for erroneous reasons. Most kink-oriented individuals hide their affiliation/preferences for the Kink culture, with only a little over one third of the population reporting being "out" in some way (Sprott et al., 2017). To change these numbers and instances of discrimination counselors must become educated and culturally aware of the Kink community. This can be done through the correction of perpetuated myths surrounding the Kink culture.

**Mental Illness**

One such myth of kink is the belief that Kink-oriented individuals tend to be mentally ill or sexually deviant. According to recent studies, the Kink population samples seem to exhibit equivalent or healthier levels of depression, self-esteem, sexual difficulties, obsession-compulsion, attachment styles, posttraumatic stress, family background, personality disorders, anxiety, and overall risk for mental instability (Connolly, 2006; Cross & Matheson, 2006; Gemberling et al., 2015; Sandnabba et al., 2002; Richters et al., 2008; Wismeijer & van Assen, 2013). The prevalence of common mental disorders such as mood and stress disorders shows little to no difference across populations with slight exceptions for members of the LGBTQ community, as also seen in the general population (Wismeijer & van Assen, 2013). One current hypothesis for the slight exception in the LGBTQ community is that these individuals are battling compounded prejudice and discrimination for their sexual orientation as well as for their identification with the kink culture, which may be adversely affecting mental health. General results in recent studies, however, state that Kink-oriented individuals do not seem to be experiencing serious mental health problems that are significantly different from the general population which includes the LGBTQ community (Gemberling et al., 2015). These studies indicate that Kink practitioners in comparison to the general population tend to have the same rates of mental illness and psychological distress (Connolly, 2006; Cross & Matheson, 2006; Richters et al., 2008). Kink practitioners also tend to be more open to new experiences, less neurotic, and more conscientious in comparison to the general population (Wismeijer & van Assen, 2013).

Another study indicated that Kink-oriented desires and fantasies seem to arise during the normal period of sexual development (Bezreh et al., 2012). The majority of individuals experience the emergence of Kink directed desires between childhood and into their twenties. Kink-oriented individuals do not seem to report any significant distress in their sexual interests and desires (Waldura et al., 2016); rather, they report distress regarding mistreatment and discrimination by individuals who do not understand or participate in the Kink lifestyle (Wright, 2006).

**Violence**

Another myth suggests that Kink-oriented individuals tend to be violent and emotionally unstable. In reality, the culture of Kink is so centered around consent that most respondents from a 2008 study share instances of violence and assault from individuals outside of the Kink community rather than from those within the community (Wright, 2008). Instances of abuse within the community typically occur when an individual purposely disregards a safe word or dishonors a hard limit; this is typically a direct result of ignorance, lack of skill/training in the community, or erroneous stigmas regarding the population (Jozifkova, 2013). Wright (2006) backs this finding up with a national survey indicating that violence, abuse, and harassment are typically perpetrated by those outside of the community, or strangers preying on
members of the community via community resources such as Kink-specialized websites. There is a concern that the need for secrecy to protect community members from mistreatment and discrimination has brought about a rise in anonymous interactions via web, putting kink-oriented individuals at risk. This is evidenced by reports within the survey of 22% of 680 respondents being victims of violence and/or harassment and yet a concerning 96% of those victimized reported not filing or pressing charges due to fear of discrimination (Wright, 2008).

The most recent study of the Kink population indicated that less than 3% of the 816 respondents reported having been the perpetrator of some form of physical assault (Gemberling et al., 2015). This and other studies have indicated consistent results that Kink-oriented individuals score equivalently or lower in areas of hostility, authoritarianism, psychopathological sadism and masochism, and psychopathy (Wismeijer & van Assen, 2013; Wright, 2008). The research suggests that Kink-oriented individuals are not a significant risk in terms of dysfunctions and violence perpetration (Connolly, 2006; Cross & Matheson, 2006; Gemberling et al., 2015).

The cycle of BDSM interaction follows a separate path than that of abuse and portrays significant differences (Jozifkova, 2013). BDSM practices are purely voluntary with extensive negotiation regarding the activities that are later enacted (Klement et al., 2016; Pitagora, 2013; Taormino, 2012; Tripodi, 2017). BDSM also includes the ability to communicate likes, dislikes, changes, and a safe word to stop all activities. There is also the presence of safe sex practices and the ability to limit risks to health and safety. Participants are able and encouraged to access information and resources for learning and training in specific techniques and activities (Klement et al., 2016; Popp & Kaldera, 2014; Taormino, 2012). Added to these differences is the psychological effect of the interactions that result in satisfaction, stress relief, and intimacy (Jozifkova, 2013). A primary goal of Kink-oriented individuals is to seek empowerment and self-actualization not only for themselves but for their partners as well (Sagarin et al., 2008; Tripodi, 2017; Wiseman, 1996).

In contrast, victims of violence and abuse typically portray psychological changes including lower self-esteem, helplessness, fear, and internalizing blame (R. Miller, 2011). Abuse also tends to follow a cycle in which there is a period of tension followed by the explosion during which the abuse takes place, followed by guilt and/or rationalization where the perpetrator typically blames the victim. Finally, there is a period of calm or a “honeymoon” stage during which the perpetrator acts with kindness and affection while the victim is lulled into a false sense of security (Jozifkova, 2013).

The BDSM cycle is different in that it starts with honest communication and negotiation where activities are discussed and agreed upon by both parties (Tripodi, 2017; Williams et al., 2014). The next stage is the scene or play activity which can be stopped at any time by either participant using a previously agreed upon code word or gesture (Taormino, 2012). The focus of the scene or play is for each participant to provide for the need and pleasure of the other(s) involved in a symbiotic fashion (Wiseman, 1996). No matter the length or success of the scene or play, aftercare follows to provide comfort and care, an opportunity to debrief what was good, bad, or neutral about the experience, and to check on the emotional and mental reactions (Jozifkova, 2013). Aftercare is personalized for those involved and can involve platonic discussion, a drink of water, intimate intercourse, or cuddling (Klement et al., 2016; Wiseman, 1996).

Female Subjugation in BDSM

Another popular myth surrounding Kink culture is that it subjugates women and promotes male chauvinistic behavior. The most recent national survey of Kink-identifying individuals indicated that 51% of respondents identified as primarily female (Gemberling et al., 2015). Of the total respondents, only about 38% of the sample reported a primarily submissive identity. It is important to note, however, that the term ‘submissive’ can be misleading in that it is actually the submissive who holds the majority of control over the negotiated interactions no matter their gender (Tripodi, 2017). The sub can request to be released from a dynamic or state their safe word at any time to interrupt, discuss, or discontinue any distressing practices.

The Kink community is open and accepting of all identities regardless of individual gender, gender identity, sexual orientation, or preference (Taormino, 2012). Women are encouraged to pursue their desires and become empowered in their sexuality (Tripodi, 2017). A recent study interviewed pro-dommes, women who act professionally in a dominant role, and indicated that the women felt fulfilled, accepted, and satisfied in their roles (Lindemann, 2011). Tripodi (2017) also found that bottoms and submissives feel that the act of submission actually increases sexual agency and empowerment through intimacy. This is something often achieved through power exchange when one or more individual relinquishes power to the leader and receives a sense of power in return since the follower(s) can take back their authority at any time with a word or gesture. This act of giving and receiving of levels of empowering intimacy is done through careful negotiation and communication (Moore et al., 2018).

Lack of Healthy and Committed Relationships

Kink culture places a great deal of emphasis on intimacy (Taormino, 2012). The culture, however, is misunderstood to be of a promiscuous and commitment avoiding nature.
Empirical evidence proves the opposite to be true. Demographics gathered in a recent survey of the Kink community revealed that 30% of respondents reported being married and/or in a lifelong commitment. About 28% of respondents reported being in a serious relationship while roughly 28% of respondents reported being either single or casually dating. The remaining 14% of respondents reported being in ‘other’ forms of relationships which include polyamorous and open relationships (Gemberling et al., 2015).

Healthy, functional, and long-lasting relationships are not rare, even in 24/7 intensive dominance and submission relationships (Dancer, Kleinplatz, & Moser, 2006). Couples report increased feelings of contentment, closeness, and trust following consensual interactions (Sagarin et al., 2008). Participants also exhibited reduction in physiological stress following a successful scene or play session. Healthy relationships outside of scenes and play are evident in individual characteristics such as absence of fear and/or recoil, lack of feelings surrounding guilt and worthlessness, evidence of respect for partner(s), ability to distinguish and separate scene and play activities from real life actions, absence of failure and compensation cycle, evidence of stable behavior, lack of isolating behaviors, lack of aggression toward partner(s), and only a mild hierarchy disparity between partners (Jozifkova, 2013).

Lack of Education

Demographic studies not only indicate stability in relationships, but in socioeconomic domains. A study conducted with the support of the National Coalition for Sexual Freedom (Gemberling et al., 2015) revealed that roughly 60% of Kink culture respondents reported having a bachelor’s degree or higher. Roughly 18% of respondents reported having an Associate’s or Vocational degree. In the same study, 59% of the respondents reported individual annual income over $30K. These numbers seem to corroborate similar demographic studies (Waldura et al., 2016; Wright, 2008). Tripodi (2017) hypothesized that, due to the high cost related to Kink activities and tools, active participation in the lifestyle requires a certain socioeconomic status.

Discussion

Recently, conversion therapy has been discredited and is in the process of being banned through legislature in specific states within the United States (Frankel, 2017). Though the premise of conversion therapy is historically understood as relating to the LGBTQ community, the action of treating Kink as pathological can have similar negative effects (Wright, 2008). Professionals are becoming aware of the harmful effects that conversion therapy and attempting to change an individual’s sexuality can have on clients (Sue & Sue, 2016). Often, treatment of Kink-oriented individuals results in the erroneous diagnosis of a paraphilic or other disorder (Lin, 2016). The stigma and non-inclusion of Kink in sessions can also be correlated to poorer treatment outcomes and poorer client retention (Sprott et al., 2017; Wright, 2006). As a result, there has been great movement toward changing the stigma of Kink culture as a disorder.

What the stigma and stereotypes of this group fail to address is the impact the mistreatment of this culture holds for community members beyond their sexual practices. Waldura and colleagues (2016) discovered that 78% of Kink-oriented respondents reported the lifestyle as having affected their mental health, indicating that their mental health is intrinsically tied to many Kink-oriented individuals’ subjective well-being. Of these respondents, 85% reported a positive impact, 13% reported both positive and negative impacts, and only 1% reported a negative impact. Another study indicated that Kink-oriented individuals tend to seek helping professionals based on referrals within the community due to fear of stigma and mistreatment (Lin, 2016). Some literature also suggests that individuals will avoid seeking treatment at all from medical and mental health professionals for the same reason (Waldura et al., 2016).

The American Counseling Association’s Code of Ethics (2014) in section E.5.b compels counselors to use cultural sensitivity when considering or diagnosing a mental disorder. Section E.5.c. of the Code of Ethics further implores counselors to recognize historical and social prejudices that lead to the misdiagnosis or pathologizing of certain groups and individuals. Counselors are to strive for awareness of any bias and/or prejudice within themselves or others in order to provide quality care (American Counseling Association, 2014). A misdiagnosis can cause irreparable harm to the client by impeding and infringing on their agency, autonomy, and individual identity. When treating a client is not possible, it is the professional’s responsibility to refer the client to a professional who can provide quality care (American Counseling Association, 2014; Sue & Sue, 2016). Clinicians should then pursue training and cultural competency seminars to ensure clinicians can work through bias/prejudice to be better prepared for future clients.

Further harm can be done if helping professionals are unaware of the differences between cultural context and constructs such as pathology, abuse, stigma, and dysfunction. Kink-oriented individuals report losing child custody battles, jobs, livelihoods, promotions, and educational opportunities as a result of disclosing their Kink orientation (Bezreh et al., 2012; Wright, 2006). Since helping professionals are also mandated reporters, knowledge of the cultural context for Kink-oriented individuals is necessary prior to concluding abuse is occurring (Jozifkova, 2013). Operating without awareness and sensitivity in regard to this culture resulting in the harmful labels as well as the suppression and oppression of a client’s self-actualization, self-acceptance and identity, quality of life, basic rights, health, and happiness is hardly
doing good.

Implications

Current research of Kink-oriented clients and their experiences in counseling is limited at this time. Among the most recent surveys covering this concern was a study that was completed in 2008. The Second National Survey of Violence and Discrimination Against Sexual Minorities identifies reports of clients being refused service until the client acknowledged and became willing to work on the abuse the professional felt was occurring (Wright, 2006). Many reported being diagnosed with a paraphilic disorder and told that they would need treatment to lead a productive life. Other Kink community members are reporting instances of managing negative and insensitive comments, battling misconceptions about Kink, and struggling against stigmas of violence and abuse in therapeutic environments (Dunkley & Brotto, 2018).

Situations such as these show the importance and need for further research and education among helping professionals. Due to the impact this culture has on a client’s well-being in all domains, counselors should be required to learn about, and become comfortable with, treating individuals who identify as having alternative lifestyles and sexualities. Additionally, since sexuality plays such a large role in the human condition, all programs would do well to require Human Sexuality courses with specific curriculum for competency with treating clients who identify with alternative lifestyles and sexualities (Dunkley & Brotto, 2018). Rodemaker (2014) calls for this when challenging organizations to offer more training for graduate students, specialized continuing education, and cultural sensitivity courses due to the lack of basic skills and comfort level required to treat this population.

Counselors should approach their work with Kink-oriented clients through a cultural lens, considering the impacts of specific culture on habits, interactions, expressions, and language. Educators and supervisors should encourage counselors to approach their sessions with curiosity and openness rather than being pathology minded. Tarshis (2014) challenges counselors to be self-aware because “when we are distracted (or uncomfortable, or appalled) we can miss the bigger picture and fail to serve a person who we are, in fact, entirely capable of serving” (p. 16). The simple solution according to Tarshis (2014) is to remember that each kink-oriented individual has issues similar to anyone else’s and to not get “hung up” on the kinky sex. In short, counselors are called to focus on the client’s perception of normal rather than the counselor’s perception of normal. A simple way to achieve this is to adopt the philosophy when in Rome (or Kink) talk as the Kinksters do. Clinicians should be comfortable with explicit, candid conversations about how the client identifies with kink as a term, preference, or lifestyle, and be open to myriad definitions.

To do this, counselors must view client concerns from an objective, client-focused angle. Since safety is a large consideration, counselors should be comfortable with determining how consensual interactions are and know enough to be able to tell the difference between abuse and consensual practice. Rodemaker (2014) called counselors to refrain from viewing clients with assumptions of what should or should not be considered a healthy relationship based on counselor preferences and instead focus on empirically based facts that determine what constitutes potential or evidence of an abusive relationship. Such factors include tendency toward high conflict, poor impulse control, feelings of worthlessness, entrapment, lack of consent, and distress (R. Miller, 2011; Rodemaker, 2014).

Finally, competency with the Kink-oriented population requires specific training. Counselors can and should identify resources to aid their understanding of the culture and practices of this unique population. Counselor educators, supervisors, and practicing counselors should be aware of resources such as books, articles, trainings, and kink friendly professionals with whom to consult. More trainings regarding kink culture are also being offered at conferences and in seminars with the prevalence of media attention. Counselors can find as well that Kink aware and Kink friendly resources are made available at the website for the National Coalition for Sexual Freedom (2019). These resources are available for counseling professionals as well as kink-identifying individuals.

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Consensual Qualitative Research of LGB Persons’ Counseling Experiences Addressing Religious/Spiritual Foci

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This article reports a Consensual Qualitative Research (CQR) analysis of the experiences of 12 participants who identified as LGB and received counseling that addressed religious/spiritual foci. Participants identified two primary and intersecting themes including an increased sense of agency and locus of control, as well as increased cognitive flexibility. Additional subthemes included manifestation of agency and locus of control intrapersonally, interpersonally, and globally. Subthemes of cognitive flexibility were also identified intrapersonally, interpersonally, and globally. Implications are discussed for counseling, counselor education, and future research.

Keywords: agency, locus of control, cognitive flexibility, LGB, CQR, spirituality, religion

Introduction

Sexuality is expressed in many forms throughout the lifespan, and one dimension of sexuality is sexual/affectional identity. For two decades, research has explored challenges to identity integration within lesbian, gay, and bisexual (LGB) individuals who also identify as religious. Although studies have increasingly sought to explore the process of identity integration, including how it takes place, few scholars have connected the ways in which personal agency, locus of control, or cognitive flexibility may have influenced the identity development process in LGB clients. The current article aims to explore the experiences of LGB clients who address religious/spiritual foci in their counseling. We decided to utilize a religious/spiritual frame for the study because some clients subscribe to a particular tradition or organized group (i.e., religious), while other clients identify as having a more personal relationship or experience with themselves and/or the universe. In doing so, the article describes how these variables may influence and interact with one another to support LGB persons in their identity integration experience when having completed counseling experiences which focused on clients’ sexual and religious/spiritual identities. The overarching goal of the project was to better understand multiple identity development and integration to provide counselors greater insight into how to better support their clients’ sexual, and overall, wellness.

Literature Review

Literature related to religious/spiritual counseling with LGB persons is robust and is continuing to expand. In a recent qualitative study with 35 lesbian, gay, bisexual, transgender, and queer (LGBTQ) participants, Beagan and Hattie (2015) noted a myriad of emotional, psychological, and behavioral consequences of conflicts between sexual/affectional identity and spiritual/religious identities, including “shame, guilt, sex negativity, disconnection from body, and severing of relationships to self and others” (p. 98). Furthermore, in their review of the literature, Anderton, Pender, and Asner-Self (2011) noted that LGB individuals have frequently attempted to resolve such conflicts between sexual/affectional and religious identities by changing their religious environment, through disaffiliating from congregations or religions that were nonaffirming of their LGB identity; attending/becoming members of a ‘para-church organization’ (Pitt, 2010, p. 58), new congregations, or religions; focusing on the development of a spiritual identity rather than a religious one; or abandoning religion or spirituality altogether (p. 268).

Researchers have concurrently identified myriad negative consequences of LGBTQ persons’ rejecting their religious identities, including increased and ongoing psychological distress (Dehlin, Galliher, Bradshaw, & Crowell, 2015;
There is other research that supports positive aspects and protective factors associated with identifying as both LGBTQ and religious/spiritual (Rosenkrantz, Rostosky, Riggle, & Cook, 2016; Rostosky, Danner, & Riggle, 2010). It is therefore not surprising that many LGBTQ individuals who identify as religious have reported an attempt to develop a spiritual identity that is ostensibly less conflictual with their LGBTQ identity (Anderton et al., 2011; Bowland, Foster, & Vosler, 2013; Bozard & Sanders, 2011; Dahl & Galliher, 2012; Pitt, 2009, 2010). Nonetheless, overall LGB individuals report high levels of minority stress (Brewster, Moradi, DeBlaere, & Velez, 2013; Crowell, Galliher, Deblin, & Bradshaw, 2014), which may contribute to their seeking counseling services at disproportionately higher rates than their heterosexual peers (Luke & Goodrich, 2015). There has been minimal previous research that has sought to understand the identity development process that may take place as part of the experiences of LGB persons who seek to integrate their religious/spiritual and affectional identities while in counseling. Therefore, findings from the current research may assist counselors to better serve future clients that may come to counseling with similar concerns.

Cognitive Development

Cognitive development is understood as a movement from a dualistic, objectivistic view of knowledge to a more subjective, relativistic view, and then to a constructivist view of knowledge (Hofer & Pintrich, 1997; Perry Jr., 1970, 1998). Streufert and Swezey (1986) defined cognitive complexity as the extent to which individuals differentiate and integrate information and as a sub-component, cognitive flexibility as an awareness of "options and alternatives" and an ability "to be flexible and adapt" (Kim & Omizo, 2006, p. 247). Recent research, however, has supported that cognitive complexity is not static, and it can vary from context to context (Brendel, Kolbert, & Foster, 2002; Granello, 2002; Welfare & Borders, 2010). Although research on cognitive development and cognitive flexibility have yet to examine their role in the identity development process of LGB persons, it seems reasonable that cognitive flexibility may play a role in the identity adjustment process for LGB persons. We believe in this connection between cognitive flexibility and identity development as identity development has often been referenced as an adaptive process when one considers new alternative while attempting to resolve identity conflicts between multiple (e.g., religious/spiritual and sexual) identities. As cognitive flexibility has been associated with positive mental health outcomes broadly (e.g., Brewster et al., 2013), we deduced that cognitive flexibility might play a role in identity development more specifically.

Personal Agency

Although there is a large literature exploring how autonomy is related to motivation (Deci, Hodges, Pierson, & Tomassone, 1992; Thompson & Luke, 2016), extant research has not explored the process of personal agency in LGB persons within the counseling process. Bandura (2001) has described agency as the capacity for human beings to be able to make discerning choices. Within Marxist philosophy, agency involves making both attributions and resultant choices independent from any structural factors (such as social class, but also religion, spirituality, gender, ethnicity, or sexual-afectional identity) that may impose social or other value-laden constraints on one’s thinking or behavior. Related to agency, locus of control (Rotter, 1954) is the extent to which individuals believe that they can control events that affect them. Though not an either-or orientation, research has explored differences in internal and external locus of control orientations across age, gender, religion, and other identity factors (Aldwin, Igarashi, Gilmer, & Levenson, 2017; Holt, Clark, Kreuter, & Rubio, 2003; Schultz & Schultz, 2004). In general, findings support that a more internalized locus of control and increased agency is associated with positive mental health outcomes (Aldwin et al., 2017; Brewster et al., 2013; Carter, Mollen, & Smith, 2014; Holt et al., 2003; Schultz & Schultz, 2004). Therefore, it is plausible that part of the counseling process related to identity integration may have contained both cognitive flexibility and locus of control. Religion or spirituality might be a process that happens to a client, based upon their family of origin, in which they do not have investment or control; this is an example of external locus of control. Conversely, individuals may elect to further invest in their religion/spirituality from their family of origin, or find an identity on their own; this internally motivated process serves as an example of internal locus of control. We were interested to understand more about how participants in our study might express their locus of control in relation to their religious or spiritual experiences.

Despite the increasing awareness in the counseling and counselor education practice literature of the salience of religious/spiritual identity for LGB persons within counseling (Kocet, Sanabria, & Smith, 2011), there have been limited studies that have examined the role of personal agency as part of identity integration (Buser, Goodrich, Luke, & Buser, 2011). Despite the need for more research in this area, studies do suggest that the counseling context may reflect similar homophobia and heterosexism as has been documented more broadly in society (Nadal, Skolnik, & Wong, 2012; Porter, Hulbert-Williams, & Chadwick, 2014). For example, Shelton and Delgado-Romero (2011) found that LGBTQ clients reported having experienced a variety of identity related micro-aggressions in counseling. This work is supported by participants in past research (Buser et al., 2011; Goodrich, Buser, Luke, & Buser, 2016), who although...
did not label them as micro-aggressions, noted a range of negative and disaffirming experiences with counselors related to both their LGBTQ and religious identities. In a phenomenological qualitative study of seven gay men, McGlasson and Rubel (2015) noted that counseling interventions were most often aligned with the counselor’s values and not those of the client. As this finding is in contradiction with the ethical imperative to operate from the cultural, religious, worldview of the client (American Counseling Association, 2014; Luke, Goodrich, & Gilbride, 2013), counselors may find post-modern theories of counseling provide a beneficial framework to address religious/spiritual issues with LGB clients (Sherry, Adelman, Whilde, & Quick, 2010).

Although the ameliorative role of counseling in the process of identity integration is intuitive, the limited research is only beginning to identify the specific counseling elements, interventions, and processes that may occur as part of identity integration. In their narratology of LGBT clients’ experiences addressing religious and spiritual issues in counseling, Buser et al. (2011) identified examples of individuals’ positive counseling experiences, as well as participants’ ability to reframe counselors’ responsibility. In addition, in a subsequent Consensual Qualitative Research (CQR) analysis, Goodrich et al. (2016) found that self-acceptance, the centrality of religious or spiritual concerns to the goal of counseling, identification with the counselor, and the counseling environment were all part of the identity integration that took place. Taken together, these findings suggested that as of yet unidentified developmental processes might be occurring within counseling that merit further examination. Other research demonstrated how lower levels of locus of control are related to LGB individuals’ psychological distress (Carter et al., 2014), while higher levels of bi-cultural self-efficacy and cognitive flexibility can promote mental health (Brewster et al., 2013). Therefore, a more thorough examination of clients’ report of how agency, locus of control, and cognitive flexibility may manifest as part of the counseling experiences of clients who identified as LGB and received counseling that addressed religious/spiritual issues is warranted. Therefore, the purpose of this study was to qualitatively explore the experiences of LGB persons who experienced religious/spiritual counseling in an effort to better understand their multiple identity development and integration while engaged in the counseling process. The goal of the project was to provide counselors and counselor educators greater insight in how to support their clients’ sexual, and overall, wellness through the counseling process when their clients seek identity integration.

**Methods**

We utilized Consensual Qualitative Research (CQR) for the design of the study as it is a collaborative methodology that allows for participants’ experiences to inform theory and supports greater applicability for the findings (Hays & Wood, 2011; Hill, 2011). The method utilizes a coding team with attention to variance across identity and perspectives as a means to increase trustworthiness. Finally, it allows researchers to identify and present domains or categories across frequency levels, allowing presenters to present data reflecting general (all or in one case), typical (more than half of the cases), and variant (at least two cases; Goodrich et al., 2016; Hays & Wood, 2011; Hill, 2011). Doing so enables researchers to present participants’ shared and unique experiences, whereas other methodologies use higher order axial themes that can diminish unique voices or experiences. Since there are multiple subgroups and voices in the larger LGB community, voice is particularly salient. Therefore, the current researchers selected CQR so as not to minimize the potential multiplicity in voice and complexity in perspective that could be lost if only soliciting one community viewpoint (Goodrich et al., 2016; Hill, 2011). Data for the study was analyzed and coded while conducting a previous study on this topic (Goodrich et al., 2016); however, due to space limitations, it was not able to be included in the previous study. The findings in the current study provide additional reflections shared by participants, beyond what was shared in prior studies, and reflects different ways in which they understood their identity integration process.

**Participants**

Twelve persons participated in the study, all of whom identified as white and cisgender. Eight participants identified as female, and four identified as male. All men identified as gay; of the female participants, six identified as lesbian, and two as bisexual. Regarding religious/spiritual identity, nine participants defined themselves as Christian (e.g., Lutheran, Mormon, Presbyterian, Roman Catholic) and three identified themselves as primarily spiritual. It should be noted that when completing demographic forms, some participants were specific to identify their religious/spiritual identity in terms of the identity from their childhood, whereas others made note that they identified them in terms of their current religious/spiritual identity. Participants currently resided in locations across the continental United States. All participants have been provided pseudonyms to protect their identities.

**Procedures**

In this study, we were interested in exploring the experiences of participants who identified as LGB and received counseling that addressed religious/spiritual issues while in counseling. We received IRB approval from our universities before the commencement of the study. Recruitment messages were solicited on two professional counseling association listservs. Members of the listservs were asked to share the study solicitation with clients that appeared to meet
the recruitment protocol. The recruitment message was also shared with university practicum and internship locations (i.e., clinical mental health counseling settings), and snowball sampling was employed; snowball sampling consisted of researchers asking participants who completed the study to identify further eligible participants.

Potential participants were instructed to contact the first author. He screened potential participants for eligibility for the study, as well as processed the written consent forms. At this time, participants were informed that they would participate in an interview that would be audiotaped for later transcription. Following receipt of the signed consent form, the first author assigned the participant to be interviewed by one of three interviewers. The interviews all occurred using a semi-structured interview guide, which was adapted from the Knox, Catlin, Caspter, and Scholosser (2005) study. Example questions included the following: How has your religious identity evolved, shifted or changed? Stayed the same? How has your LGBTQ identity evolved, shifted or changed? Stayed the same?

Positionality

Prior to engagement in the qualitative research, we found it important to explore and identify our potential biases and reactions that could have been relevant to the study (Hays & Singh, 2011). Although the current study only has two authors, the original research team wherein the data was collected consisted of four persons: three interviewers and an auditor. Two members of the original team identified as white heterosexual women, one as a white heterosexual male, and one as a white gay man. All identified as white and were employed as counselor educators in tenured or tenure-track positions. In the current study, the CQR coding team included two master’s students working with the second author to identify illustrative examples of identified themes, with a third master’s student serving as an auditor. One master’s student identified as a gay, white, male, another as a heterosexual, bi-racial, female, and the third as a heterosexual, white, male. The five-person research team for the current study also identified holding a spiritual identity and significant relationships with religion or spirituality over time. As recommended by Hill, Thompson, and Williams (1997), each researcher described their expectations and beliefs related to the research questions, including identification of potential challenges, areas of concerns, or issues to attend to in the interview and data analysis process. The researchers discussed their biases at the start of the project. All researchers discussed their concerns that sexual orientation change efforts might be discussed by participants and noted their philosophical position opposed to this. One researcher noted his bias that religious and spiritual issues would be handled poorly in counseling with LGB persons, due to his own experiences of this in personal counseling. Another researcher noted her own guilt about not previously handling religious and spiritual issues in counseling according to what is now recognized as best practice. Given the mixed findings in other research, the research team also expressed concern about how the topic of religion or spirituality in counseling might be seen as more distressing and less life-enhancing when discussed by LGB participants. All researchers agreed to continue to journal their thoughts and biases as they progressed through the study and remained committed to exploring this material throughout the project to remain clear and transparent to appropriately collect and analyze data.

Data Analysis

Data were analyzed using CQR as outlined by Hill et al. (2005). CQR method strategically utilizes a coding team, with attention to variance across identity and perspectives as a means to increase trustworthiness in the study (Goodrich et al., 2016; Hays & Singh, 2011). From participants’ experiences, we examined how they discussed their experience of religious/spiritual counseling, as well as how that appeared to influence their identity development (Goodrich et al., 2016).

After the interviews were assigned, taped and transcribed, the three interviewers reviewed each of the transcripts and open coded them; the interviewer who did not conduct the interview coded the transcript first, followed by the second interviewer who did not interview the participant. The interviewer then open coded the transcript last, with all transcripts being coded and distributed in a round robin fashion until all open coding was finished. The team of interviewers (known in CQR as “judges”) then met, via conference call, to discuss their impressions and understandings of the data present in the transcripts one at a time.

A second team of CQR judges, including the second author and two master’s students also engaged in coding the transcripts. The two master’s students worked together to code the transcripts, and then they met with the second author to argue to confirm, debate, and refine codes until there was consensus across the team. Following this process for each of the transcripts, the first and second author then met for a separate conference call to collapse the open data into larger developed core ideas. Core ideas then were subsumed into conceptual labels, which categorized core ideas into broader categories. After the judges agreed on categories, the third master’s student serving as auditor (who sat out all interview and the two-step coding processes) reviewed the core ideas and categories with two untracked, clean transcripts to explore accuracy of the domain and word coding, as well as provide any challenges to the judges regarding agreement with the outcome of the coding and consensus building process. Following receipt of auditor feedback, the authors met as a team to reexamine the data in a cross-analysis process and reach new consensus on word and domain coding. Following protocols for CQR, all data were then classified into categories.
expressing that data was general (categories found in 11-12 transcripts), typical (categories found in 6-10 transcripts) or variant (categories found in 2-5 transcripts; Goodrich et al., 2016; Hays & Singh, 2011).

Findings

Participants identified two intersecting cognitive themes as resulting from their exploration of both their LGB and religious and/or spiritual identities within their own counseling. In the first theme, 11 of the 12 participants talked in varied ways about their increased sense of agency and locus of control. In a second general theme, 11 participants described evidence of cognitive development and increased cognitive flexibility.

Agency and Locus of Control

As noted previously, 11 participants noted an increased sense of agency and locus of control. Participants in this study recognized and described increased agency as occurring across three contexts, including a) intrapersonally, within themselves, b) interpersonally, within the therapeutic relationship, and c) globally, within the various communities to which participants belonged.

Intrapersonally (7; typical). As a typical theme, seven participants described ways they recognized they had increased agency within themselves. Leah described how her involvement in a 12-step program increased her agency and internal locus of control when saying, “The 12 steps, part of that is looking at myself and claiming responsibility for one’s life.” Applying this when reflecting on her earlier experiences in counseling, she noted, “I think I was closed...I had been in denial for a long time.” Having learned the experience of claiming responsibility for one’s life, Leah noted the ways in which she could move past her denial to understand her own responsibility in her life and the choices that she could make for a better future.

Gabriel noted that earlier in his identity development process, he had this “big, huge boundary that I put up was there’s nothing fundamentally wrong...with me and I’m not gonna [sic] be gay anymore.” He went on to say that “I had my own journey through my inability to navigate, negotiating sexual boundaries, which I had.” Through his journey, he was able to come to terms with his sexual identity and form healthier boundaries in intimate relationships. By claiming his identity and understanding how his sexual behavior influenced his perception of himself, he discussed being able to move to a healthier life.

Naomi described that the process of identification had to happen slowly, first with herself, and then with selected family members. Even then, she had to be strong, since it would take those selected family members time to adjust to accept her identity. She stated when she first started, “I am not ready to come out to everybody. At first, I told my mom and she was like you know you’re not. I was like yes I am. I am who I am and it’s not going to change.” Although Naomi was able to find the strength to come out to others, she shared that she had an initial challenge with her first experience. Prepared, however, she reported being able to stand in her truth even when her mother doubted her new identity.

Intrapersonal cognitive shifts did not just occur for participants based upon their sexual identity; they also occurred regarding their faith traditions. As such, these participants reported struggling not with their sexual identity, but their religious identity once they understood that they were LGB. In reconsidering her faith tradition, Hope stated

My faith, I really believe that God does have a plan for things and that He intervenes in our lives for different reasons and that He has an impact on the world. The things that happen in the world and around us are at least somewhat influenced by God’s plans and his purposes.

Similarly, Rebekah noted that her perception of herself and her spirituality had to change to better reconcile her spiritual and gender identities; “I had to evolve out of that where women were very feminized and actually oppressed and the men had the authority period.” Finally, Aaron noted development of a meta-awareness of his religious positionality, saying

That’s kind of how I view the world. I view the world in a different way than someone who’s Protestant or someone who’s Jewish or someone who’s Muslim, or whatever that is. Because of that history that I’ve had, with that faith [Catholicism].

Interpersonally (11; general). Participants also noted ways in which they found agency in their interactions with others; they could not only take responsibility or control over their own lives and actions, but they were also able to claim this in how they interacted with others. In particular, participants spoke about the ways in which they claimed agency in relationship to the counselor or therapist (defined as such by participants) they saw for personal counseling as part of their identity journey. This included their finding or pursuing of a certain counselor as well as their need to switch or terminate a relationship or change how their relationship was functioning in context with their counselor.

Leah most strongly evidenced increased agency and locus of control in talking about her selection of different counselors over her lifetime. She began,

One was picked for me as a result of an assault. That [relationship with the counselor] went absolutely nowhere. Then, the next person [counselor she saw] was probably in my
late 20s. She was a woman...and then a
counselor...referred me to this guy.

She then went on to discuss her selection of a counselor follow-
ing her involvement in a 12-step program, noting at first, “I
found [him] by accident” but then explained that she met
him in graduate school since he “was on a list of people that
we could to kind of [sic] interview about some favorite topic
of ours,” and that “when some stuff started coming up very
powerfully about my sexual identity, I thought of him.” As
such, Leah saw counseling as a process, and that at different
times, different counselors might serve her in different ways.
Leah claimed her agency through whom (which counselor)
she wished to work with at different junctures of her life,
knowing that each counselor might be able to provide her
something different when she was faced with different life
challenges.

Hope explored how she made decisions about the coun-
selors she later sought support from:

I think it’s imperative that if that’s important
to you that you seek out somebody that is gonna
[sic] help you in the best way...If that means
phone interviews or going to speak with a ther-
apist for an initial session and to feel them out
about some of those things, that is absolutely
imperative that you do that.

Beth had a different experience of finding a counselor, but
still found ways to employ her personal agency in the coun-
seling relationship:

I first went to see her when I was in gradu-
ate school and training to be a therapist. It was
largely because it was one of the requirements of
the school, then I was able to find a community
of people, you know people that weren’t just on
television or in a book...I went in deciding I was
going to be very open about who I was because
that was what I was there to talk about...I really
at that stage of my life when I was almost thirty
I was...ready to stop being on the fringe and,
you know, be at the center and without having
to change me.

Gabriel expressed agency in the opposite direction when
he discussed his first counseling relationship: “I saw him
once and I said I just don’t think he’s the kind that I don’t
ever want to talk to again.” From the first meeting, Gabriel
was able to see that the counselor would not be able to pro-
vide him what he needed, or in the way that he needed it.
Therefore, the agency he expressed was in ending a coun-
seling relationship. Similarly, Hope also met with a coun-
selor who she initially thought might be useful for her, but
experiences in counseling proved otherwise: “I met with a
She continued, “For more social support and roots, since I don’t have any family left now, I’ve been active more in the Unitarian church. I identify myself as Unitarian if other people are Unitarian.” She later expounded that being Unitarian allowed her the opportunity to combine her spiritual and political lives together as that was her typical experience of the Unitarian Church environment. She further reported that this also allowed her greater opportunities to integrate and openly live as a queer person in her spiritual community.

Hope discussed how counseling led her to her future professional career, as well as informed her how she might interact with others within that profession:

Being a professional counselor, I just really am like I consider myself a professional. I have an identity. I have to be careful about what I say and do. I just feel like that I do need to be picky and that I need to be careful about who I’m with and they need to understand my concerns

Finally, Aaron identified the impact of his prior counseling experiences on the choices he makes now:

It does color how I think about raising spiritual themes [in his own work as a counselor]. Both places that I’ve worked since this experience do identify as either highly religious or highly spiritual. It’s something people do think about raising in their counseling sessions.

Cognitive Development and Cognitive Flexibility

Eleven participants identified three contexts wherein their cognitive development took place and resulted in increased cognitive flexibility, including a) intrapersonally, related to increased differentiation in self-concept, b) interpersonally, related to increased differentiation of beliefs within their religious and/or spiritual communities, and c) globally, related to increased integration of information resulting in more critical thinking.

Intrapersonally (6; typical). Six participants explored how they experienced cognitive development intrapersonally, related to increased differentiation in their self-concept. Leah described an example of her cognitive development when it was dualistic, recalling, “I had moments where a reframe might have taken me a minute to look at. Most of it was just soâ€œmost of the things people shared with me, like in-sights, really helped me tremendously.” In this quote, Leah notes that she recognized that previously, she would not have been able to accept a reframe immediately, and now, following counseling, she could accept two sides. Similarly, at the start of the counseling relationship, Isaiah too had a dualistic understanding of the world: “I could see nothing divine in being gay. Therefore, it was a flaw or something that was a temporary condition, and therefore by being a condition it was correctable.” Gabriel similarly echoed the experience that Isaiah had shared:

Spiritual counseling cut us off from–because it’s not us, it’s the devil, it’s Satan, it’s the enemy, it’s flesh so it really isn’t you. Then you never learn to embrace the thing that you are afraid of. You never learn to create a boundary to protect yourself. You never learn to negotiate or navigate when you are sexually active in same sex relationships.

Finally, Rebekah expressed similar concerns related to her early identity development experience: “Then I automatically thought I was going to hell. I prayed for six years without ceasing. I wouldn’t act on it and wouldn’t even mention the word gay. I couldn’t accept it...after I acted on my feelings I still had some issues thinking about whether I was going to hell or not.” Here, Rebekah spoke about identity as feeling/thought versus behavior, and again spoke retrospectively about having been more dualistic. She later shared that over time, her views evolved from an either/or view of religion to a more flexible understanding.

With time, participants began to notice a shift or change in how they thought about themselves, or the cognitive flexibility that they had. Naomi described how she initially needed to adjust her spiritual experience in the opposite direction (from belief to nonbelief) when attempting to resolve the conflict between her sexual and spiritual identities, but then was able to come to a point of acceptance and integration: “I didn’t believe and just went with the flow and as I got a little bit older I kind of got more independent and grew and just grew into my beliefs how I have now.” Beth discussed a similar change when she stated, “developmentally I was just ready to change on every level.”

In talking about his cognitive development and cognitive flexibility, Aaron noted that early on, “I took a very rigid or a very dualistic view of the world...and this is the only way anyone is ever going to look at this.” He went on to describe the development of relativistic thinking when noting differences between his thinking and that of his counselor, “I defined myself as a Catholic, although not practicing all things in the sort of traditional sense. She really kept on coming back to that. Every single session, actually.” He later reported that this later served as a barrier in his relationship with his counselor, but he was able to own a different interpretation of his experience and hold his two distinct identities together even when challenged by others.

Interpersonally (8; typical). Eight participants noted that they had cognitive development changes interpersonally, related to increased differentiation of beliefs within their religious and/or spiritual communities. A number of the participants discussed their shifting beliefs from the spiritual system from which they grew up. As an example, Gabriel
stated, “These things happen and I have a different idea of what that is now.” Naomi further explained that now when she interacts with people from her faith tradition with whom she disagrees, she holds firm to the idea that “I have my beliefs and you have your beliefs.” Hope explained her process of differentiation with a bit more detail, explaining how she distinguishes herself from her religion of origin:

I was like, don’t talk to me about this God can fix everything. That God has a plan. I believe some of that stuff myself, but when you’re angry and you’re hurting because you’ve had so many losses and you’ve had—I’ve had a lot of losses but I’ve also had a lot of trauma in my life. I think it’s okay for me to question.

She later expanded upon how she now views her spirituality: “what I believe and how I function in this world is to kinda [sic] go about my life in terms of being caring and concerned and trying to help others.”

Not all participants had to take a one or the other view on their spirituality, however. Leah reflected on her growth in counseling and articulated a relativistic view: “I think part of it [her shift] was a recognition of some kind of guiding power that even got me to go to AA. I can look back and see things that happened in my life that allowed me to open to sitting in a room and talking about God, when I was not believing in God or angry at God, or whatever.” Thus, Leah was able to find her own interpretation of her spirituality not through her original church, but a 12-step program, and integrate the spiritual components from that program to better fit her own lived experience.

Participants did not report interpersonal development only in their religious experiences; some also reported this development as part of the counseling relationship. Aaron displayed how his relativistic thinking impacted his therapeutic relationship when continuing to describe his differing formulation of his Gay and Catholic identities as compared to that of his counselor, saying:

I honestly think she genuinely felt for me and felt like she was helping me; like I was doing something hurtful against myself in terms of holding this identity. Although, I explained to her, kind of like I explained to you, I don’t and I didn’t practice traditional Catholicism in the most strictest [sic] of terms. I think her intention was to be helpful and caring and to ensure I had a healthy self-image or self-identity, or whatever that was. I think she really missed the boat in terms of how I define myself and how I practice that.

Joseph provided deeper context to this idea when he explained why he ultimately explored a counseling relationship to better understand his sexual and spiritual identities:

I think my intention was to get an outsider’s view, to either be told whether it was wrong or right. I think I had been so in my head for so long in trying to deal with things on my own and not having any clear answer that I wanted somebody to give me a clear and concrete answer. Somebody who didn’t really have an investment in things. I didn’t want to hear it from a pastor. I didn’t want to hear it from anybody who—I don’t know who I wanted to hear it from. I just wanted something concrete in front of me that people who wouldn’t have a lot of investment could tell me. I felt they could be more honest.

Globally (7, typical). Finally, a typical theme found in participants’ narratives included global cognitive development, which was defined as increased integration of information resulting in more critical thinking. One example is Isaiah, who spoke about the suicidal ideation he had following his experiences in conversion/reparative therapy due to his evangelical Christian spirituality and experience of queer attraction.

I finally came to a point where I determined okay, this isn’t working. Everything you’ve been taught and told is not working. I began to have suicidal thoughts where I thought the only way I’m gonna [sic] end this is if I take my life. I thought I have got to find a way to do this so that it looks like an accident because it was a real concern. I had four children. I did not want my children spending the rest of their lives going to counseling so that they can come to terms with their dad’s suicide. I spent some time planning it out.

Isaiah then spoke about moving through his identity conflict through the experience of his suicide planning. He knew that suicide would not be an option because of his family, so he would need a new way to move through the world. He began the process of coming to terms with his sexual identity, and later, found a new spiritual identity that better fit his needs.

Anna also spoke about finding a new spirituality and being okay if others did not understand or find the same meaning in her spiritual experiences. She explained “I mean, I can translate into other things if there’s something they make or do that I don’t have an association with, I mean, I can figure out what–like the spirit animal or guide is just something to connect to as an assistant. I do that, I just don’t necessarily do it the way that somebody else might understand it.” Similarly, Hannah discussed the need to hold to her own experience, even when others did not understand or criticized her new identity:
The other day I had a friend of mine who told me that she feels my relationship is a sin and gave me a whole long discussion. I was actually able to handle the situation fine. I didn’t cry about it. It bothered me but I was able to say this is how she feels and this is not how I feel. I was able to talk with my partner about it and kind of not get so despairing about it. That’s what I mean with a good day. When I was able to handle the hateful things that are said and the negativity, and that kind of thing. Not that it won’t affect me but I will be able to handle it better than I would have in the past.

Hope reported facing similar experiences with conservative members of her familial and social environments, and learning to respond in new and different ways: “I’ve had to obviously adapt over the years from a more conservative viewpoint to being more open and more holistic about my choices and things because I realize that’s who I am. I can’t really change that. I’ve tried. I think I’ve tried to change it but I can’t. I’ve tried to deny it but it’s just there.”

Beyond learning new and different ways to respond to others, some participants discussed new ways that they sought to think about and integrate understandings about themselves, as well as where they put their energies. As Beth noted,

I just kept selecting the community that would that would validate me...each time I put myself in a community, I was more and more integrated, and...you know and it’s like now I can sit around in a room with a group of straight colleagues and if the question comes up about our difference, then I’ll say sure you want to know anything.

Similarly, Joseph explained, “Now I’ve opened up to everything. I feel like I have a better understanding of what it’s really supposed to be about and not all of these rules and political beliefs.” Finally, in exploring a better synthesis of which he feels he was, Aaron described the integration of his Gay and Catholic identities, reflecting increased cognitive flexibility and integration of critical thought. He noted, “There were a number of priests who actually privately identified as gay” who helped me develop more of a spiritual identity and a religious identity, a Catholic identity while still being gay. So, where I didn’t attend traditional Mass my freshman year, later in my sophomore year and through my senior year I both attended Mass and actually used to do the first reading or the second reading for the church.

**Discussion**

The current study suggests that agency and locus of control, as well as cognitive development and increased cognitive flexibility, may be evident in the reports of LGB clients who addressed religious/spiritual concerns in counseling. More specifically, findings also demonstrated that participants described enacting both of these themes differentially across intrapersonal, interpersonal, and global domains. Participants described agency and locus of control as typical (n = 7) at the intrapersonal level, general (n = 11) at the interpersonal level, and variant (n = 5) at the global level. Likewise, participants described cognitive development and increased cognitive flexibility as typical (n = 6) at the intrapersonal level, typical (n = 8) at the interpersonal level, and typical (n = 8) at the global level.

The findings of the increased agency and internal locus of control support earlier research that has noted the association of both with increased psychological functioning (Aldwin et al., 2017; Carter et al., 2014; Holt et al., 2003; Schultz & Schultz, 2004). Although not examined to date, one might expect LGB individuals to have higher levels of psychological functioning and thereby further research is needed to distinguish the temporal relationships involved. As of yet, however, it remains uncertain if there is a causal relationship between psychological functioning and agency and internal locus of control or vice versa. Future research should address if any such relationship may exist.

The findings of differential enactment of agency and internal locus of control across the intrapersonal, interpersonal, and global level add to the complexity of our understanding. In discussing her own experiences with counseling in Critchfield and Pula (2015), author Alison Bechdel articulated that as “an individual approach, it [counseling] has great political power. To help people access their own autonomy and agency is as political as it can get” (p. 402). Future research can, however, explore potential developmental differences in the emergence and enactment of agency and internal locus of control across contexts. It is our belief that it is possible that similar to other developmental differences in this domain (Bandura, 2001), agency and internal locus of control first appear interpersonally with the counselor’s support, then intrapersonally, and lastly more globally.

The findings of cognitive development and increased cognitive flexibility also support earlier scholarship that noted the complexities in “creating safe spaces in treatment that allow for an exploration of fantasy, creativity, and self-determination, while simultaneously being capable of formulating our patient’s problems and developmental histories in such a way as to identify troubling emotional symptoms or maladaptive compromises that are tied up in concerns of gender and sexuality” (Critchfield & Pula, 2015, p. 409). While affirmation, self-disclosure, and skill-building in response to minority stress have all been identified as potentially useful...
in work with LGBTQ clients (Porter et al., 2014), reframing may provide a particular benefit because it has been implicated as a specific intervention skill that can assist in disrupting false dichotomies and expand one’s frame of reference in other contexts with other populations (Buser et al., 2011; Goodrich et al., 2016). The current study cannot identify what specifically accounted for participants’ cognitive development; however, future research could examine the impact of specific therapeutic approaches, theoretical frameworks, and specific counseling skills (e.g., reframing) on clients’ cognitive development and increased cognitive flexibility.

It is of interest that participants reported relatively equal manifestation of cognitive development and increased cognitive flexibility across contexts, being enacted as typical (n = 6) at the intrapersonal level, typical (n = 8) at the interpersonal level, and typical (n = 8) at the global level. Although no prior research could be identified with heterogeneous client samples for comparison, there is some suggestion in prior research that LGB clients may have unique experiences with heterosexism and homophobia prior to and within counseling (Robertson, Pote, Byrne, & Frasquilho, 2015) that, as a component of minority stress, could arguably inhibit some aspects of cognitive development in LGBT individuals, restricting cognitive flexibility specifically. Thus, one possible explanation for how typical this theme evidenced across intrapersonal, interpersonal, and global contexts is that when an LGB individual experiences a counseling relationship with lower levels of heterosexism and homophobia, there is a rebound effect and cognitive development intensifies. Future research could incorporate pre- and postmeasures of cognitive complexity across both heterogeneous and LGB samples in counseling.

Limitations

As with all descriptive qualitative research, caution is needed in interpreting the current research results or extending the findings to other populations. The small, self-selected convenience sample of LGB participants does not represent the perspectives and experiences of the trans or queer communities within the collective LGBTQ population. While the current sample represented some diversity regarding age, gender, and geographic region, it had minimal racial and ethnic diversity. Thus, it is unknown how similar or different these 12 participants were to other LGB individuals who seek counseling, or to those clients whose counseling experiences did not address religious or spiritual concerns, especially those outside of Christian traditions. Further, although this CQR analysis adhered to the methodological steps outlined by Hill et al. (2005) and incorporated additional trustworthiness checks recommended by Hays and Singh (2011), there is nonetheless risk of researcher bias. In particular, the researchers recognized a priori that consistent with research and their earlier personal and professional experiences, they held tentative assumptions that religious or spiritual counseling may have been mishandled in most counseling settings with LGB persons. These assumptions were monitored through the research process, and researchers journaled after interviews to ensure that they kept that bias in check. They also ensured that the semi-structured interview protocol employed in the study specifically addressed positive and life-affirming experiences through religious and spiritual counseling to ensure that participants had explicit opportunities to speak about both positive and negative experiences. Finally, use of auditors also supported that results were data driven and findings reflected participants’ expressed experiences.

Implications

There are several implications for the findings from this study that includes two primary and intersecting themes of increased agency and locus of control, as well as increased cognitive flexibility across intrapersonal, interpersonal, and global domains. Although this study did not explore or establish a temporal sequence for increased client agency and locus of control, counselors may still find it beneficial to formally or informally assess both agency and locus of control throughout their work with LGB clients who also identify as religious or spiritual. Regardless of presenting issue, it is feasible to establish treatment goals for increased agency and locus of control at the intrapersonal, interpersonal, and global levels because of prior association with increased psychological functioning (Aldwin et al., 2017; Carter et al., 2014; Critchfield & Pula, 2015; Holt et al., 2003; Schultz & Schultz, 2004). Toward this end, counselors can consider incorporating specific interventions aimed at addressing client agency and locus of control (Goodrich et al., 2016) as part of overall treatment. Moreover, the reported prominence of increased cognitive flexibility in this study and the prior research that associates this with positive mental health outcomes (Brewster et al., 2013) warrant counselors’ use of counseling skills that have been demonstrated to expand client perception and challenge dichotomous thinking such as reframing and raising discrepancy (Buser et al., 2011; Goodrich et al., 2016).

Counselors, as well as counselor educators and supervisors, should consider the how in this study, LGB clients described therapeutic ruptures resulting from counselors focusing more on the counselor’s concerns than those reported by the client. Specifically, clients described an over focus in the counseling relationship around one aspect of client’s sexual/affectional orientation or spiritual identity which was perceived by clients as being more about the counselors’ ‘own stuff,’ than it was the client’s goals. Accordingly, counselors, counselor educators, and supervisors can review the ACA Code of Ethics (2014) concerning therapeutic interactions with clients and commit to avoiding untested or harmful therapeutic models, such as sexual orientation change.
efforts. Also, counselors, counselor educators and supervisors should also acknowledge the multicultural/diversity statement of the Code of Ethics (2014), which speaks to both a person’s affectional orientation and religious/spiritual identity and reflect on how to assimilate both in their work, as well as counseling competency documents by the Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC; ALGBTIC LGBQQIA Competencies Taskforce et al., 2013; Burns et al., 2010). Lastly, counseling training programs are asked to consider how to address counselor bias so that clinicians can better work past their issues to be present and focus on the needs of the client whom they are serving.

Conclusions

The present study was a qualitative exploration of 12 participants who identified as LGB and received counseling that addressed religious/spiritual issues. Participants identified two primary and intersecting themes, including an increased sense of agency and locus of control, as well as increased cognitive flexibility. Through intrapersonal, interpersonal, and global experiences, each participant addressed how they grew in their sense of self and identity through their counseling and personal experiences. The findings of the study support that persons can hold intersecting identities as LGB and religious or spiritual. There are therapeutic opportunities that address this in counseling, as long as the personal concerns or biases of the counselor do not work to negatively influence the therapeutic process.

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A Population at Risk: Counseling Sexual Minorities with a Serious Mental Illness

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Sexual minorities are at a greater risk for experiencing a serious mental illness (SMI) compared to heterosexuals, and sexual minorities suffering from a SMI experience stigma and discrimination that leads to a greater need for counseling services. Current research does not address the needs of sexual minorities with a SMI and how to prepare counselors to work with this population, as most sexual minorities with a SMI find that counseling services do not meet their unique needs. The purpose of this transcendental phenomenological study, grounded in a Husserlian philosophical and minority stress model conceptual framework, was to explore the experiences and perceptions of counselors who provide counseling services to sexual minorities with a SMI. Data were collected from six participants using semistructured interviews and followed a thematic data analysis process, ensuring thematic saturation. The results of this study highlighted many themes regarding the unique needs of sexual minorities with a SMI such as multiple minority stressors, negative counseling experiences, and the impact of family, as well as counselors’ perceptions regarding the lack of preparation in graduate school to work with sexual minorities with a SMI. Study findings may improve counselors’ understanding of the needs of sexual minorities with a SMI so they may provide more effective counseling services. This study also highlights the importance of training counselors to work with this population and may support the efforts of counselor educators.

Keywords: sexual minority, serious mental illness, counseling, counselor preparation

Introduction

There are approximately a half million sexual minorities with a serious mental illness (SMI) in the United States (Bostwick, Boyd, Hughes, West, & McCabe, 2014). Sexual minorities are almost two times more likely to experience mental health issues that lead to an increase in depression, bipolar disorder, and other serious mental health diagnoses than their sexual majority counterparts (Bariola, Lyons, & Lucke, 2017). Additionally, sexual minorities with a SMI have higher levels of comorbid psychiatric disorders, which makes treatment and counseling more difficult (Mizock, Harrison, & Russinova, 2014). A SMI is often associated with schizophrenia but can refer to any mental health diagnosis that requires inpatient and outpatient treatment and results in significant disability in a major life domain of living, learning, working, or socializing (Pratt, Gill, Barrett, & Roberts, 2013). For the purpose of this study, the researchers defined a SMI as an individual who has a diagnosis of bipolar disorder, major depression, or schizophrenia. Even though sexual minorities with a SMI are more likely than their heterosexual counterparts to report a mood and anxiety disorder, both nationally and internationally, sexual minorities with a SMI underuse mental health services (Kidd, Howison, Pilling, Ross, & McKenzie, 2016; Seeman, 2015). Sexual minorities with a SMI experience a double stigma based on their sexual orientation and mental health diagnosis, and many report that counseling services are often stigmatizing, inadequate, and discriminatory (Mizock et al., 2014). Furthermore, the factors of discrimination and internalized homonegativity make recovery more challenging for sexual minorities with a SMI (Bariola et al., 2017; Meyer, 2013; Mizock et al., 2014). Thus, several intertwined factors complicate the treatment and recovery of sexual minorities with a SMI.

It is important to understand the needs of sexual minorities with a SMI that are not being met in counseling services and how these services can improve. There is evidence that many sexual minorities with a SMI do not use mental health services, supporting the need for additional training of counselors working with this population to increase and improve services (Kidd et al., 2016; Mizock et al., 2014). Researchers
and counselor educators need to explore other ways to educate culturally competent counselors so that counselors can address the needs of sexual minorities with a SMI (Bidell, 2014). With additional research, counselors and counselor educators can provide services that are more effective to sexual minorities with a SMI.

Training

Counselors receive training that prepares them to be culturally sensitive and fulfill certain competencies, but training can be improved to include a focus on sexual minorities with a SMI. As part of their practice guidelines, counselors must adhere to the American Counseling Association (ACA; 2014) Code of Ethics that encourages counselors to seek additional training to provide ethical service and practice within their boundaries of competence. The Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC LGBQQIA Competencies Taskforce et al., 2013) has also highlighted competencies for counselors regarding sexual minorities. However, even though counselors receive training in both the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5; American Psychiatric Association, 2013) and multiculturalism, there is a lack of direct training on the specific needs of sexual minorities with a SMI (Kidd et al., 2016).

Multicultural Education

Over the past years, the Council for Accreditation of Counseling and Related Educational Programs (CACREP) has increased their emphasis of multicultural education in counseling programs (Brooks, Kim, Moye, Oglesby, & Hargrett, 2015). However, there is a greater focus on race and ethnicity, which does not fully prepare counselors to work with sexuality or sexual identity (Collins, Arthur, Brown, & Kennedy, 2015). Furthermore, counselor education programs must shift from providing education and awareness of sexual minorities to teaching skill development to increase counselor competence in working with sexual minorities with a SMI (Graham, Carney, & Kluck, 2012). Therefore, the purpose of this phenomenological study was to understand the experiences of counselors who provide counseling services to sexual minorities with a SMI. By understanding counselors’ experiences, counselors and counselor educators can begin to gain a deeper understanding of counselors’ needs when working with sexual minorities with a SMI. Furthermore, understanding the needs of sexual minorities with a SMI may help counselor educators enhance their teaching, which may improve the services for sexual minorities diagnosed with a SMI (Kidd et al., 2016).

Methods

This study is grounded in a Husserlian approach focused on the intentional, conscious knowledge of the participants (Dowling & Cooney, 2012; Moustakas, 1994). Intentionality highlights the connection of the mind to the object, whereas the object exists solely in the mind (Moustakas, 1994; Pivcevic, 2013). Focusing on intentionality is the foundation of a descriptive approach that concentrates on the participants' conscious awareness (Heidegger, 1978; Moustakas, 1994). According to Heidegger (1978), to fully understand and deduce an experience, researchers must suspend their thoughts and ideas in a process known as phenomenological reduction. Bracketing opinions and ideas meant that personal experiences would not bias the results (Chan, Fung, & Chien, 2013), and it allowed for the truest experience from the participants that is essential, basic, and irreducible (Moustakas, 1994; Pivcevic, 2013). Further, this design allowed for an additional framework to organize the results in a context already in use among mental health practitioners.

Minority Stress Model

Because the minority stress model suggests that the mental health of sexual minorities is adversely affected by the experiences of stress, the model can be applied to the clinical treatment of this population. Individuals who occupy marginalized minority statuses face institutional and interpersonal discrimination, prejudice, and stigma (Bostwick et al., 2014). Therefore, it is best to explore multiple factors to understand the health disparities among minority groups (Meyer, 2013). According to Meyer (1995), individuals experience minority stress from three different processes. First, individuals experience stress from the environment and external events due to their minority status. Second, individuals begin to anticipate and project specific external events, becoming hyper vigilant (Meyer, 1995). Last, individuals tend to internalize the negative events and prejudices from the external factors (Hendricks & Testa, 2012). The minority stress model provides organizational structure for counselors working with sexual minorities with a SMI because it (a) provides a systematic way to address minority stress in the actual clinical situation, (b) highlights the clinical utility of examining the specific components of minority stress, and (c) demonstrates the use of sexual minority affirming psychotherapy for people struggling with minority stress (Alessi, 2014, p. 49). Additionally, the minority stress model supports a process in which minority stress influences mental health for sexual minorities (Baams, Grossman, & Russell, 2015). Incorporating this conceptual framework with a Husserlian approach helped the researchers formulate interview questions for the data collection process that supported the overall research question (Patton, 2014).
Participants

This study consisted of six female individuals who hold a terminal counseling license in their respective states. Of the six individuals, five identified as Caucasian and one identified as African American. Only one of the six identified as a sexual minority. At the time of the study, three of the six participants were living in New Jersey, one participant in Pennsylvania, one participant in Maryland, and one participant in Illinois. Five of the six participants were in their early to mid-40s, and one participant was in her early 30s. Additionally, four of the six participants graduated from a master’s program that is accredited by the CACREP. Finally, each participant had experience working with sexual minorities with a SMI across different settings, such as intensive outpatient counseling, outpatient counseling, clinical mental health setting, and private practice.

Role of the Researcher

As a part of qualitative research where the researcher is considered the instrument responsible for data collection and analysis (Englander, 2012), the primary researcher for this study completed all data analysis and collection procedures, and the secondary researcher provided triangulation of data and feedback. The primary researcher of this study was a doctoral candidate and licensed professional counselor. The secondary researcher was also a licensed professional counselor and counselor educator in a CACREP accredited doctoral program.

Data Collection

Purposive, criterion, and snowball sampling methods were used to recruit participants. Data collection began by sending an e-mail to the recruitment agency seeking participants who met the following criteria: (a) professional counselor currently working with a sexual minority with a SMI, (b) the client will self-identify as a sexual minority, and (c) the client will have a SMI diagnosis. Using this criterion to select the population for the study was important because all the participants had a shared experience of what it is like to work with sexual minorities with a SMI (Patton, 2014).

A semistructured interview format allowed for flexibility; all interviews contained six main questions with time for additional probing questions (Qu & Dumay, 2011). The six main questions were as follows:

1. Tell me about your experience working with sexual minorities with a SMI.
2. What has your experience been regarding the specific needs of sexual minorities with a SMI?
3. What is your experience related to your clients’ biggest struggles with stigma, prejudice, and discrimination?
4. What has your experience been regarding training to work with sexual minorities with a SMI?
5. How can counselor education programs improve training for future counselors to work with sexual minorities with a serious mental illness?
6. How can counseling services be improved to provide more effective services to sexual minorities with a SMI?

Though an interview guide supports the overall structure of the data collection process, the flexibility with a semistructured interview supports asking additional probing questions and changing when questions are asked as long as the interviewer is not manipulating the participants to respond in a specific way (Englander, 2012; Seidman, 2013). The ordering of the questions was changed after the first interview, with two questions switched to allow for a better flow of conversation and to enhance the depth of data. The most important element when using a semistructured interview is the relationship and human connection between interviewer and interviewee (Seidman, 2013). The interviews took place in Zoom videoconferencing platform, focusing on building a connection between interviewer and interviewee, and were scheduled for a total of 90 minutes during which the interview protocol guided the process and allowed for specific open-ended questions for researchers to gather rich data (Jacob & Furgerson, 2012; O’Reilly & Parker, 2012).

Throughout the interview process, it was important to ask the participants to elaborate on concepts and ideas they mentioned and not make assumptions. Additionally, to ensure the focus was on the participants, a reflective journal was used to bracket ideas before and after each interview. Bracketing was important so researchers could write about personal experiences and refrain from skewing questions or otherwise detracting from the experiences of participants (Chan et al., 2013; Kafle, 2013; Moustakas, 1994). Attention to confidentiality and security was imperative, so upon completion of each interview, data were saved and stored with a password-protected file. Member checking (Birt, Scott, Cavers, Campbell, & Walter, 2016), providing each participant with a summary of the interview, allowed the participants to provide feedback for clarity or elaboration.

Data Analysis

To begin the data analysis process, each interview was listened to in its entirety to ensure files were not corrupted and transcription was possible (Patton, 2014). A word-by-word transcription process of each interview was completed and imported into NVivo for storage and data analysis (see Bernauer, Lichtman, Jacobs, & Robinson, 2013). Once uploaded, each interview was reviewed a second time to allow for immersion in the data with attention to repetitive and
It is evident that participants were repeating common themes (see Fusch & Ness, 2015). Therefore, data analysis ended at six participants, eliminating the need to collect additional data. Some participants provided richer, in-depth data with their examples as evident by the higher nodes in those interviews. Nevertheless, the participants’ experiences collectively supported the overall themes in this study.

Trustworthiness

To ensure trustworthiness in data collection and analysis in this study, an interview protocol was used to keep each process as similar as possible. A semistructured interview process allowed for flexibility with probing and follow-up questions. Additionally, providing participants with a summary of the interview provided participants an opportunity to clarify elements of the interview. Though no participant changed anything after the summary, member checking was helpful in enhancing the trustworthiness of this research (see Birt et al., 2016). Following a specific approach to data analysis and using NVivo to organize the data also enhanced the trustworthiness of the data. Being clear, providing adequate descriptions, and being transparent about the study support the credibility of the results and trustworthiness.

Results

Research Question: What are the Experiences of Counselors Who Provide Counseling Services to Sexual Minorities with a SMI?

Theme 1: Multiple minority stressors. Sexual minorities with a SMI often experience multiple minority stressors due to their sexual orientation and mental health diagnosis (Meyer, 2013). Experiences of multiple minority stressors lead to greater physical issues and affect overall well-being of individuals (Cochran & Robohm, 2015; Mereish & Poteat, 2015). Sexual minorities experience multiple levels of minority stressors that hinder the acceptance process (Mizock et al., 2014). In this study, minority stress can be categorized by two separate subthemes, external stressors and internal stressors.

External stressors. Based on participant responses, external stressors were most evident at work and at school. For example, participants summarized that at work, adult clients have feelings of being different or isolated that can impact an individual’s ability to fit in or seek professional advancement. Participant 2 noted:

And I think it took her a really long time to feel comfortable in the workplace because of the social boundaries there. But I do feel like there was some, you know, some stress there for her. She feels like in some ways promotion wise and advancement wise, she was held back due to being a sexual minority with a SMI.

An individual feeling like sexual minority status or mental health diagnosis hinders professional advancement or connection with peers enhances the lack of trust in the workplace, leading to further stress and marginalization for a sexual minority with a SMI (Hellman, Klein, Huygen, Chew, & Uttaro, 2010).

Further discussed by participants is the similarity between adult clients experiencing issues at work with adolescent clients experiencing stressors and stigma in school. For instance, Participant 1 indicated:

For the youth, I would say definitely their school has a huge impact. I will say it’s like relationship building, friendship. Kind of the normal experiences that you have. But I think they’re colored with "but I’m a sexual minority" or “I have a mental illness,” or "I’m a sexual minority with a serious mental illness."

Each minority status impacts adolescents’ experiences in school, which can lay the groundwork for further development in adult life (Meyer, 2013), and according to the participants in this study, external stressors from multiple minority statuses affect their clients’ lives.

Internal stressors. The results also indicated that internal stressors are derived from multiple minority statuses. Participants discussed that during adolescent development, students are learning effective coping skills to work through their minority stressors. However, many sexual minorities with a SMI have difficulty with appropriate coping skills, and this may lead to self-medicating behaviors, self-harm, or even suicide. Participant 6 commented:

Also, learning coping skills, like "how do I actually deal with this" because she never really learned how to deal with her symptoms of depression or her symptoms of irritability or mania related to that. So I think part of that was really
Regardless of the minority stressors, participants added the internal conflict regarding religious factors compounded these stressors. As Participant 4 identified, "The added stress if, you know, clients were raised in a religious or a household that doesn’t embrace differences. The stress of maybe feeling lonely, more so than maybe your average heterosexual person, and not feeling truly accepted."

Through many of the interviews, emphasis was on how the internal stressors continue to impact individuals. Many sexual minorities with a SMI have issues with low self-esteem and self-identity (Meyer, 2013). Using a strengths perspective to overcome self-esteem issues may also support identity development for many sexual minorities with a SMI who have difficulty understanding who they are as individuals. As participants highlighted, there appears to be an impact on sense of identity as clients begin or continue personal identity exploration. Counselors continue to work through the minority stress with clients to solidify a sense of identity. Ultimately, sexual minorities with a SMI have many needs that are a direct result of both the external and internal stressors from the multiple minority statuses they hold (Kidd et al., 2016; Meyer, 2013).

Theme 2: Negative counseling experiences. Sexual minorities with a SMI have negative experiences with counseling that impact current and future counseling services (Kidd et al., 2016; Mizock et al., 2014). Many sexual minorities with a SMI report that counseling services are often inadequate and further stigmatizing, leading to underuse of services (Kidd et al., 2016; Mizock et al., 2014). Often these negative experiences impact sexual minorities with a SMI to seek out future counseling or open up to their current counselor (Hellman et al., 2010; Robertson, Pote, Byrne, & Frasquilho, 2015). For example, Participant 1 noted:

What I find is that in their effort to establish a relationship like they almost have to check with me to make sure that they’re going to get the experience that they’re looking for because they’ve had negative experiences in the past. So bad, they’re coming to me already with some negative experiences from the past and looking for affirming counseling.

Participants hypothesized that sometimes negative experiences affect clients’ comfort sharing specific topics and issues in session or feeling further stigmatized. Whether clients feel stigma based on their sexual minority status or their mental health diagnosis, it is important that they can feel comfortable. An individual’s lack of comfort with identity can perpetuate internalized homonegativity, which can lead to greater mental health issues (Bariola et al., 2017). Lack of comfort with a counselor can also make a client hesitant to open up (Robertson et al., 2015). Participants focused on how the hesitancy that sexual minorities with a SMI experience in counseling settings inhibits their ability to develop a trusting relationship. As sexual minorities with a SMI have greater negative experiences, they have more difficulty building a trusting relationship with a counselor. As Participant 5 highlighted:

And if they’ve had more than one experience like that and several of my clients have, then they are, they’re not open to the process and it takes a while to trust. But honestly I think the more bad experiences they’ve had with the counselor the longer it takes for me to establish trust in and establish a safe environment for them.

Hesitancy and resistance with counseling not only impacts the client but according to some participants also impacts the counselor.

When clients have negative experiences with other counselors, their desire to seek counseling or form a positive relationship may be impacted. Authenticity can help both the counselor and client, and helps create a new relationship (Lamoureux & Joseph, 2014). The experiences of the participants in this study supported that negative relationships impact sexual minorities with a SMI in counseling, which has been supported by other research (Lamoureux & Joseph, 2014).

Theme 3: Family impact. Family support may often be a protective factor to many sexual minorities with a SMI and impact the therapeutic relationship (Seeman, 2015). However, many sexual minorities with a SMI may not be able to rely on family members for support (Luckstead, 2004). Therefore, it is important to connect with family members when possible. Through discussion, having all parties on the same page increases the consistency in and out of the counseling setting and allows for more reinforcement of counseling interventions. However, sometimes family members involved in the client’s treatment may contradict the recommendations of counselors and impact the client’s recovery. For example, Participant 1 noted, “Their family members have a huge impact on the services and treatment that they receive. It ranges from family members who don’t believe in medication at all, and so they’re not actively promoting their family members receiving medication management.” Therefore, it is important for counselors to explore the role of family support with sexual minorities with a SMI. Even though many sexual minorities with a SMI may find it difficult to rely on family members (Borden, 2014), seeking out the balanced support can help clients with their identity search.
are important to provide services to meet the needs of sexual minorities with a SMI. Working with sexual minorities with a SMI, counselors are aware of the skill set that they bring to the counseling relationship. Because many sexual minorities with a SMI encounter negative counseling experiences, it is important for counselors to recognize and understand how their skills impact the sessions. For example, unconditional positive regard is an important aspect for counselors to develop in their relationships with clients (Rogers, 1967). Participants mentioned the importance of having unconditional positive regard as a major strength for counselors providing positive support to sexual minorities with a SMI. Though many sexual minorities with a SMI may not be able to rely on family support, counselors can explore support to increase another protective factor for sexual minorities with a SMI who have unique needs (Hellman & Klein, 2004). For example, according to Participant 5:

I soon learned that my acceptance and unconditional positive regard for everyone allowed me to just excel in that area. I think it goes back to my ability to unconditionally accept everybody for who they are and where they are.

Similar to unconditional positive regard, empathy is also an important aspect for counselors (Rogers, 1967). Both empathy and unconditional positive regard are important for the counselor to express verbally and nonverbally. To fully empathize with clients and provide unconditional positive regard, counselors need to be present and listen to their clients (Rogers, 1967). Supporting this, participants asserted that counselors can block out distractions and be in the moment with their clients. Doing so can be helpful for counselors working with sexual minorities with a SMI.

One participant discussed how being in the moment and truly listening to the client allows counselors to begin to understand the client’s experience and not make assumptions. Instead of assuming what sexual minorities with a SMI are feeling and experiencing, counselors can use their basic counseling skills to validate their clients. For example, Participant 3 identified, "A large part of my role is at times normalizing it for the client but also validating their experience as unique and their own experience." Therefore, listening to, validating, and normalizing the client’s experience allows a counselor to build that therapeutic relationship that supports the client outside of the office (Rogers, 1967). Further, according to one participant, sometimes counselors need to be an advocate for their clients, especially when working with sexual minorities with a SMI. Counselors need to remember the skills they bring to the counseling relationship and their role in providing services to sexual minorities with a SMI. These skills can be used to help overcome clients’ past negative experiences as well as match the unique needs that sexual minorities with a SMI bring into counseling.

**Theme 5: Inclusive environment.** As counselors use their skills to combat negative client experiences, it is important to create an inclusive environment that is supportive and safe for sexual minorities with a SMI (Robertson et al., 2015). As Participant 3 stated, "It’s important to just create a really inclusive space." Creating an environment of inclusivity can combat the external world where many sexual minorities with SMI experience discrimination and prejudice (Meyer, 2013). Expounding on this, participants discussed the importance for counselors to be explicit when creating a safe environment, an environment that clients know is inclusive even before coming into counseling.

As clients seek and find counselors who promote a safe environment online, it is also important to promote inclusivity in the counseling environment. For example, Participant 6 discussed:

One thing is like the actual setting up the location in terms of like when the client walks into the office. Like what is in the office, is it geared towards a specific mission. Are the colors really like, are they neutral or are these geared towards a specific population? Are there pictures of people or pictures of people that relate to me? Are there resources only for Whites? Young families? Or are there resources for everybody you know? Are you being all inclusive or not? I think that’s something to increase counseling services for [sexual minorities with a SMI].

Overall, there was a consensus that inclusivity and creating a safe environment helps clients feel more comfortable to open up to counselors and even adhere to counseling services. Ultimately, making sure the environment is inclusive of the needs of sexual minorities with a SMI may support more adequate services.

**Theme 6: Clinical supervision.** For the sixth theme, participants in this study highlighted the importance for counselors working with sexual minorities with a SMI to seek and receive clinical supervision. Clinical supervision is an important aspect of counselor development and a core component of the counseling profession (Bernard & Goodyear, 2013). When counselors are working with sexual minorities with a SMI, relying on clinical supervision is helpful to navigate the various needs of this population.

With the extensive needs of sexual minorities with a SMI, clinical supervision may be used to direct services or to prevent burnout (Bernard & Goodyear, 2013). As one participant highlighted, clinical supervision is also seen as an important transformative process for counselors working with sexual minorities with a SMI. Participant 1 illuminated:

Supervision for me has been the most transformative process of all of my training and education because it was you know that tandem,
Participants highlighted that supervision affords the counselor the ability to be present and more supportive to their clients as well as increase their knowledge of sexual minorities with SMI.

**Theme 7: Lack of education and preparation.** Perhaps one reason participants expressed that clinical supervision is important when working with sexual minorities with a SMI is due to the lack of education and preparation counselors receive. Counselors do receive training on multiculturalism; however, there is a lack of training and skill development to work with sexual minorities with a SMI (Graham et al., 2012; Kidd et al., 2016), which the counselors in this study supported. Lack of education on a population can lead to ignorance that perpetuates stigma or a lack of confidence to support the population (Graham et al., 2012; Kidd et al., 2016). Sometimes, as pointed out in this study, the lack of training also leads to services that do not meet the needs of sexual minorities with a SMI or further marginalizes the population. As Participant 1 commented, "I think that [the lack of training] definitely needs to be addressed because the experiences of [sexual minorities with a SMI] in counseling, again like my own clients have said themselves, this is not always the best."

Additionally, lack of training may sometimes lead to a lack of comfort or confidence. For example, Participant 3 noted:

> Because I think counselors are uncomfortable. Some counselors are uncomfortable talking about sex and sexual choices and sexual identity. You know I think it will give counselors more knowledge, and with more knowledge and more practice comes a greater level of comfort addressing some of these issues that are just so difficult to address, and they cause discomfort. You know for not only the counselors but also for the clients.

Changing this lack of training is imperative to increase a counselor’s competency to work with sexual minorities with a SMI (Mizock et al., 2014); however, training can also be made on a systemic level. As times change and the needs of clients evolve, the profession needs to evolve as well. Because many counselors do not receive adequate training or preparation to work with sexual minorities with a SMI, they often rely on basic counseling skills and making a conscious effort to create a safe environment (Kidd et al., 2016; Mizock et al., 2014).

**Theme 8: Active counselor competency.** Even though participants highlighted minimal training related to sexual identity or working with individuals with a SMI, they also discussed not receiving specific training to work with sexual minorities with a SMI. As a result, the participants noted the need to seek the education themselves and increase their knowledge. As the participants illuminated, counselors figure out ways to increase their competence to better serve their clients. Participant 1 commented:

> I just kind of, I guess create my own knowledge, bed of knowledge and doing my own research with you know looking up articles and journals and doing my own like self-study of what does this population need or what we have to do to find out information about our clients.

Participants discussed increasing their competence by reading journals and engaging in self-exploration. Some continue to enhance their professional development using other modalities. Additionally, participants highlighted conferences as effective professional development for counselors, especially when seeking knowledge on sexual minorities with SMIs. As counselors continue to seek additional training and knowledge, there is an increase in competence working with sexual minorities with a SMI (Graham et al., 2012). By increasing their competence to work with sexual minorities with a SMI, counselors are conforming with the ACA (2014) *Code of Ethics* as well as working to address the unique needs of this population.

**Discussion**

The experiences of the participants in this study confirm and extend the findings identified in the current literature. As Scott, Lasiuk, and Norris (2016) noted, the needs of sexual minorities with a SMI are multifaceted. Due to multiple minority identities, many sexual minorities with SMIs experience stress resulting in stereotyping, negative reactions, and stigmatization (Graham et al., 2012; Meyer, 2013; Mizock et al., 2014). These factors were evident in this study and were highlighted in the first theme that emerged from the data analysis. The participants in this study expounded on multiple stressors, both internal and external, that are imposed on sexual minorities with SMIs. Some of the stressors that the participants discussed were self-esteem issues, self-identity issues, lack of coping skills, stigma in school and the workplace, and societal pressures. The internal struggles highlighted in this study are similar to the identity and internalized homophobia that Meyer (2013) has discussed.

Additionally, the participants in this study illuminated the negative impact of past counseling services on recovery for sexual minorities with a SMI. Often, sexual minorities with a SMI feel alienated, stigmatized, and discriminated against,
which leads to a perception of inadequate counseling services (Barber, 2009; Kidd et al., 2016). Many of the participants reported that a negative counseling experience leads to a lack of comfort, acceptance, openness, trust, and a lack of follow up. Furthermore, participants noted that the more negative experiences sexual minorities with a SMI have with counseling, the more difficult it is to build rapport in the counseling relationship. These findings are congruent with Hellman et al. (2010), who concluded that the discrimination sexual minorities with SMIs experience in treatment influences clinical rapport and adherence to treatment.

Along with being aware of negative counseling experiences, it is important to create a safe environment, which the study’s findings and previous research support (Hellman et al., 2010). As Robertson et al. (2015) pointed out, many sexual minorities with a SMI have found it difficult to discuss relationship needs with clinical staff due to not feeling safe or fully secure. Therefore, as the participants commented, it is important to be explicit in the acceptance of all people to create an inclusive space and promote a safe environment. These findings support initiatives to improve the mental health of sexual minorities and create a safe space for individuals with a SMI (Robertson et al., 2015). For example, both the CACREP and the ACA have emphasized the importance of counselors being more multicultural competent to work with individuals who hold a minority status (American Counseling Association, 2014; Council for Accreditation of Counseling & Related Educational Programs, 2016). Additionally, leaders of the ALGBTIC have highlighted skill competencies for counselors who work with sexual minorities and emphasized that counselors should be more mindful and aware of affirming language (ALGBTIC 2013). Last, both the National Alliance on Mental Illness and the Movement for Global Mental Health continue to address stigma associated with mental illness in anti-stigma, stigma free campaigns (Movement for Global Mental Health, 2013; National Alliance on Mental Illness, 2018).

Despite the competencies that counselors are trained to address, issues like past negative experiences and creating a safe environment, literature has indicated a lack of services that meet the unique needs of sexual minorities with a SMI (Kidd et al., 2016; Mizock et al., 2014; Seeman, 2015). Much of the literature supports the idea that the lack of services is directly correlated to the lack of focused training (Lamoureux & Joseph, 2014; Mizock & Fleming, 2011; Sutter & Perrin, 2016). The participants in this study supported this notion by commenting on the lack of specific training they received in their graduate studies. Additionally, the participants reinforced the need for counselors to receive more education and training to increase their comfort level when working with sexual minorities with a SMI. To compensate, the participants noted the importance of taking an active role in gaining competence by attending conferences and trainings, immersing themselves in literature, and speaking to peers.

Although many of the results confirm existing knowledge in the field, there is some information from this study that may contribute new knowledge related to counselors’ work with sexual minorities with a SMI. Many sexual minorities with a SMI often find it difficult to rely on family or friends for support (Borden, 2014), but the participants in this study expounded on the impact of family on sexual minorities with a SMI. Participants highlighted the importance of counselors trying to incorporate family into services for more support as many sexual minorities with a SMI are seeking family acceptance, though participants acknowledged how many sexual minorities with a SMI are often neglected by family members, sometimes to the extent of being disowned.

This study also expands on literature pointing out the need for a safe environment. Although Hellman et al. (2010) highlighted the importance of creating a safe environment for sexual minorities with a SMI, counselors working with this population may lack skills to support this environment and the needs of the population. Therefore, this study can provide counselors a foundation of skills that may be effective in creating a safe environment. For example, the participants reiterated the importance of being authentic, empathetic, and providing unconditional positive regard for the client. Additionally, the participants mentioned being present with clients, being open to learning from the client, and having the awareness when additional resources are needed.

Finally, though supervision is an integral aspect of a counselor’s development and the counseling profession, there is a lack of research supporting the need for clinical supervision when working with sexual minorities with a SMI. The participants in this study recalled the importance of clinical supervision when working with sexual minorities with a SMI. Participants recounted the experiences of clinical supervision in providing support and additional education as needed.

Limitations

One limitation of this study related to the small sample size. Though a sample size of six meets the recommendations of phenomenological researchers, and the interviews reached data saturation (Fusch & Ness, 2015; O’Reilly & Parker, 2012), the location of participants may limit the study. For example, five of the six participants live in more liberal areas of the country. Though phenomenological research is only concerned about the perceptions and experiences of participants and not about generalizing to the larger population (Moustakas, 1994), perhaps experiences of counselors living in more conservative parts of the country would be different.

Additionally, the participants do not solely work with sexual minorities with a SMI. Therefore, they have different experiences working with various clients. Though participants
were either currently working with sexual minorities with a SMI or have worked with one in the past year, their recollection of their experiences may not be fully accurate. Nevertheless, this research highlights the experiences of this sample insofar as they can recall the experiences. The experiences of the participants may contain their own perceptions of working with sexual minorities with a SMI; however, the themes of this study match other research and decreases the extent to which this is a limitation.

Finally, a limitation of this study is the role of researcher. As a professional counselor who has worked with sexual minorities with a SMI, it was important for bracket personal opinions before and after each interview to reduce researcher bias (Kafle, 2013). Bracketing personal opinions and ideas was also important for reducing personal bias regarding the results of the study (Chan et al., 2013). Doing so allowed for focus on the experiences of participants.

**Future Research**

The purpose of this study was to gather and explore the experiences and perceptions of counselors who provide counseling services to sexual minorities with a SMI. From this study, counselors can begin to understand the needs of counselors working with sexual minorities with a SMI. Because the needs of sexual minorities with a SMI are multifaceted (Scott et al., 2016), and individuals with a SMI use an array of support services to improve their recovery (Pratt et al., 2013), a follow-up study focused on the experiences of psychiatrists and advanced practice nurses who work with sexual minorities with a SMI will provide a different perspective.

With additional insight and understanding of different perspectives, counselors can have more knowledge of the needs of sexual minorities with a SMI, increasing counselors’ understanding of how to best serve this population.

Additionally, the results of this study illuminated the value and impact of family members of sexual minorities with a SMI. Because most sexual minorities with a SMI have difficulty relying on family for support (Borden, 2014; Gamarel, Reisner, Laurenceau, Nemoto, & Operario, 2014), gaining the perspective of family members and the role they play in supporting sexual minorities with a SMI may be helpful. If counselors understand the strengths, barriers, and stories of family members supporting sexual minorities with a SMI, they may have more knowledge on how to best support family members when attempting to incorporate them into their client’s support system. Furthermore, counselors may gain a deeper understanding of the struggles that many families have experienced, allowing them to help their clients learn skills to help repair some familial relationships.

Another recommendation of this study is to explore the role of clinical supervision when working with sexual minorities with a SMI. Clinical supervision is important for the professional development of counselors (Bernard & Goodyear, 2013). Moreover, the participants in this study identified clinical supervision as an important aspect of working with sexual minorities with a SMI. Therefore, it may be important to explore clinical supervisors who supervise counselors providing counseling services to sexual minorities with a SMI. Studying the supervisors may highlight specific skills or ethical dilemmas that counselors struggle with, leading to trainings and professional development courses to meet those needs.

As a final recommendation, further research should be focused on developing training that can enhance counselor education and improve the services for sexual minorities diagnosed with a SMI. Though this study may pinpoint areas in a counselor education program where counselors can increase their competence, additional research is needed to gather data that may shape the development of an elective course or certificate for counselors working with sexual minorities with a SMI. Developing a specific course can provide the opportunity to track a counselor’s confidence and competence to work with sexual minorities with a SMI.

**Implications for Practice and Training**

This research study and the recommendations can improve training and education for counselors working with sexual minorities with a SMI. With empirical evidence for counselors and counselor educators, counselors can advocate for better training to provide equal and fair treatment of every individual (Laureate Education, n.d.). Additionally, this study provides information for organizations like the ALGBTIC and the CACREP to advocate for improved counselor education and treatment for sexual minorities with SMI.

Because sexual minorities with a SMI are currently underusing services because they believe the services are inadequate or stigmatizing (Mizock et al., 2014), having better-trained counselors may improve the quality of services and reduce the perceptions of discrimination. With improved services, sexual minorities with a SMI may begin to adhere to counseling services, make better progress, and fulfill their definition of recovery. Increasing the use of services can foster greater well-being for this marginalized and disadvantaged population.

Additionally, the themes identified in this study confirm the literature in the field validates the use of a Husserlian framework. Because a Husserlian framework provides a foundation for participants to describe what they perceive, sense, and know in their immediate awareness and experience (Moustakas, 1994), this study was able to capture the participants’ descriptions of their experience to inform my research question. Therefore, future researchers can use a Husserlian framework to structure their studies and gather rich data that will provide a deeper understanding of a topic.
The implications of this study support the notion that individuals experience stress due to minority status as discussed by Meyer (2013) in the minority stress model. Individuals who occupy marginalized minority statuses face institutional and interpersonal discrimination, prejudice, and stigma (Bostwick et al., 2014). The results of this study suggest that sexual minorities with a SMI, holding double minority statuses, face discrimination, prejudice, and stigma. Because this study further validates the minority stress model, researchers can continue to use this conceptual framework to ground future studies regarding marginalized populations.

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LGBTQ* Responsive Sand Tray: Creative Arts and Counseling

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This article builds upon a heuristic framework for sand tray in supervision, multicultural focus areas, and the supervisory roles of teacher, consultant, and counselor to propose a framework for LGBTQ* responsive sand tray. This proposed framework provides supervisors with a creative arts-based structure to assist both counselors-in-training and practitioner supervisees in working with LGBTQ* persons, in a way that is culturally responsive and affirmative of their LGBTQ* identity. This article provides a group supervision case example and discussion to highlight the enactment and process of utilizing the proposed creative-arts framework.

Keywords: sand tray, supervision, counselor education, LGBTQ, creative-arts, creativity

Introduction

Scholars have argued that unlike purely talk-based therapies, tools, or interventions, creative arts have the potential to awaken new possibilities related to how individuals experience, examine, or engage in meaning making within a complex world and society (Gladding, 2010; Kapitan, Litell, & Torres, 2011). Creative arts have been used with a variety of different populations (e.g., students, people of color, queer persons, adolescents), a multitude of issues and concerns (e.g., trauma, sexual identity and wellness, anxiety), and to address multicultural and social justice issues (Gladding, 2010; Paone, Malott, Gao, & Kinda, 2015). Within the creative arts literature, there is a range of modalities, such as dance, art, poetry, music, humor, and sand tray (ST; Gladding, 2010). ST is an expressive therapeutic modality that examines both intra- and interpersonal issues using ST materials such as sand, water, a tray of some sort, and various inanimate figurines (Isom, Groves-Radomski, & McConaha, 2015) as a form of expression (Pappas, 2015). Unlike the well-documented benefits of creative arts within the counseling literature, the conceptual and empirical scholarship within the counseling profession associated with ST is in a state of development (Gladding, 2010). This is particularly relevant when considering the use of ST with developing multicultural competence or with marginalized populations and communities, such as the Lesbian, Gay, Bisexual, Transgender, and Queer* (LGBTQ*) community. Given the multiple communities represented within the acronym LGBTQ*, an asterisk is intentionally used to indicate that the identities named are incomplete, intersectional, and fluid (Luke, Goodrich, & Bond, 2015).

Despite the gap in the literature, creative arts, particularly ST, have been identified as a useful tool or intervention for professional counselors, counselor educators, and supervisors (Gladding, 2010; Mullen, Luke, & Drewes, 2007; Paone et al., 2015; Perryman, Moss, & Anderson, 2016). Therefore, ST has been identified as an underutilized framework for developing student or supervisees' multicultural competence (Paone et al., 2015), especially when working with marginalized populations. ST provides a creative modality to assist students or supervisees in exploring, communicating, and making meaning of their internalized struggles or less accessible information (e.g., preconscious, unconscious) using symbols and miniatures in the sand (Garza-Chaves, Timm, & Oeffinger, 2018; Gladding, 2010; Paone et al., 2015). Thus, like other creative arts, ST has the potential to provide a framework for counselors to explore and expand their multicultural competence (Paone et al., 2015), while increasing their ability to support marginalized communities in exploring their own experiences, needs, and mental health with a modality that has been positioned as culturally responsive (Garza-Chaves et al., 2018; Paone et al., 2015). Therefore, this article will build upon the current counseling ST literature by adapting the use of ST to benefit a specific marginalized community, the LGBTQ* community, or more specifically, LGBTQ* persons with intersecting affectional orientations, genders, and sexual identities, given that the LGBTQ* acronym includes each of the intersecting identities (ALGBTIC LGBQQIA Competencies Taskforce et al., 2013; Cavanaugh & Peters, 2019).

Developing the use of ST to serve the LGBTQ* com-
munity is crucial, as the LGBTQ* community faces many issues, such as discrimination, bullying, and homelessness (Goodrich & Luke, 2015); internalized homophobia and genderism (Farmer & Byrd, 2015); dating and sexuality (Cavanaugh & Peters, 2019; Zeglin, Van Dam, & Hergenrather, 2018); emotional, physical, and sexual abuse (Dank, Lachman, Zweig, & Yahner, 2013); and a variety of mental health and substance-use-related issues (Cochran, Björkenstam, & Mays, 2017; Thorne et al., 2018). More importantly, scholars have suggested that counselors and related mental health professionals are not adequately prepared to work with those within marginalized affectional orientations and gender identities or the many issues LGBTQ* persons face (Luke & Goodrich, 2012, 2013), such as dating and sexuality (Cavanaugh & Peters, 2019; Zeglin et al., 2018). As a result, this article builds upon the literature preparing counselors to provide effective, culturally responsive, ethical, and just services to those with diverse affectional orientations, gender identities, and sexualities, through clinical supervision.

### Sand Tray: A Creative Approach

As noted above, the purported utility of ST as a creative arts intervention has been established in the counseling literature (Bratton, Ceballos, & Ferebee, 2009; Garrett, 2013, 2015b; Isom et al., 2015; Lyles & Homeyer, 2014; Nickum & Purgason, 2017; Paone et al., 2015), albeit, mostly conceptually. Despite the conceptual nature of ST within the counseling literature, multiple studies have empirically examined the process and benefits of ST within the counseling profession (Paone et al., 2015; Stark & Frels, 2014; Swank & Lenes, 2013). The use of ST has been documented across time and cultures, and has developed out of personal phenomenological hermeneutic research (De Domenico, 1988; Graham, Scholl, Smith-Adcock, & Wittmann, 2014). Originally developed out of Lowenfeld’s (1979) world technique and modified by Kalff (2004), ST has been purported to promote healing and growth, effectively respond to trauma, increase self-esteem, facilitate the counseling process and counteract resistance, and attend to culturally specific issues, such as gender and race (Chang, Ritter, & Hays, 2005; Paone et al., 2015). Stark and Frels (2014) suggested that ST also offers opportunities as a collaborative assessment for counselor development, especially with counselors-in-training. As an expressive arts supervision activity, ST provides a shared symbolic language for supervisee and supervisor, and can assist in exploring case conceptualization and counseling dynamics (Chang et al., 2005; Stark, Garza, Bruhn, & Ane, 2015), as well as increasing supervisee self-awareness and expression (Carnes-Holt, Meany-Walen, & Felton, 2014; Garrett, 2015a; McCurdy & Owen, 2008).

Over the past decade, the counseling research has begun to examine the utility and effectiveness of ST in counseling and supervision (Anekstein, Hoskins, Astramovich, Garner, & Terry, 2014; Garza-Chaves et al., 2018; McCurdy & Owen, 2008). While ST has been implicated in its ability to tap into both conscious and unconscious creative processes (Anekstein et al., 2014; Paone et al., 2015), research has supported the ways in which ST utilizes visual, kinesthetic, and expressive communication (Stark et al., 2015), arguably all aspects of creative expression. Supervisees have described their experiences with ST in supervision as positive (Markos, Coker, & Jones, 2008; McCurdy & Owen, 2008) and for these reasons, Goodrich and Luke (Goodrich & Luke, 2015) identified the particular utility of expressive, experiential, and creative approaches in supervision of counselors working with LGBTQ* clients. Because ST can be utilized within a variety of theoretical approaches, such as Person Centered, Jungian, Adlerian, Gestalt, Developmental, and Psychodynamic (Isom et al., 2015; McCurdy & Owen, 2008; Perryman et al., 2016), supervisors have a range of ways in which they can incorporate ST into extant supervision models (Anekstein et al., 2014; Carnes-Holt et al., 2014; Stark, Frels, & Garza, 2011). For example, Garrett (2015b) described use of journaling as an extension of the ST experience in supervision, while others incorporate photography, painting and drawing, or titling, as well as various forms of narrative and reflective practices (Luke, 2008; Mullen et al., 2007). Although the literature does not suggest an ideal theoretical lens or creative approach, Perryman et al. (2016) indicated that the selection of a theoretical lens should be based on several factors, such as one’s training, supervisee or supervisor development level, context, population, and supervisory relationship. Thus, supervisors and counselor educators should consider such factors when selecting an appropriate and ethical framework for ST within supervision.

### Incorporating Sand Tray into Supervision of Counselors Working with LGBTQ* Clients

Within counseling and other related mental health professions, clinical supervision has long been recognized as the primary modality for intrapersonal and interpersonal skill development (Bernard & Goodyear, 2013; Bernard & Luke, 2015). Such professional development supports the expansion of counselors’ attitudes, beliefs, knowledge, skills, and actions when working with diverse populations across different professional settings and contexts (Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2016). As a result, multiple approaches have been developed and utilized as a means of supporting counselors’ multicultural and social justice development within supervision (Bernard & Goodyear, 2013; Bernard & Luke, 2015). One such area includes creative arts and more specifically, ST (Anekstein et al., 2014; Bernard & Goodyear, 2013; Carnes-Holt et al., 2014; Stark et al., 2011).

As mentioned above, creative arts have been used to promote a wide variety of professional skills, behaviors,
and abilities, such as expressive and reflective processes (Gladding, 2010), increased self-other awareness (Bratton, Ceballos, & Sheely, 2008), and increased access to intuition, empathy, and emotion (Carnes-Holt et al., 2014). In supervision, Stark et al. (2014) suggested that as a specific creative arts intervention, ST could uniquely assist supervisees to conceptualize, establish counseling and supervisory goals, and enhance the counseling and supervisory relationships. Furthermore, ST has recently been extended into multicultural counseling training contexts as well. In a qualitative study with 43 counselors-in-training, Paone et al. (2015) found that counselors-in-training reported that ST facilitated their expression and new learning in supervision as well as being a positive and meaningful group experience. The authors further argued this study provided initial support for the use of ST as an intervention aimed at assisting students or supervisees in expressing difficult emotional or sensorimotor feelings and experiences, thereby allowing them to become more cognizant, insightful, and emotionally attuned to their feelings and biases that could have otherwise impeded their multicultural competence or abilities as counselors.

Other research supports the use of ST in group contexts (Bratton et al., 2009; Kestly, 2010; Swank & Lenes, 2013), with researchers theorizing that the group context reduces isolation and promotes a sense of universality (Yalom & Leszcz, 2005), specifically related to multicultural counseling training difficulties (Paone et al., 2015). That said, there has been limited discussion about how ST can be employed in group supervision (Luke, 2008) and virtually no literature that specifically focuses on the utility of ST with supervisees who are working with LGBTQ* clients. For the purposes of this manuscript, "supervisees" refers to counselors-in-training, counselors accruing hours towards licensure, and licensed practitioners receiving supervision.

Goodrich and Luke (2015) stated that while the counseling and supervision literatures have increasingly responded to the needs of LGBTQ* persons, clients who identify LGBTQ* continue to frequently report negative counseling experiences that do not reflect recognized standards, best practices, or counselor multicultural competence (Buser, Goodrich, Luke, & Buser, 2011; Goodrich, Buser, Luke, & Buser, 2015). Therefore, Luke and Goodrich (2015a, 2015b) purported that supervision offered a direct mechanism to increase counselors’ multicultural competence, social justice competence, and clinical competence when working with LGBTQ* individuals. Increasing counselors’ ability to serve LGBTQ* persons is of the utmost importance, given that persons who identify as LGBTQ* seek counseling services at disproportionately higher rates than their heterosexual and gender normative peers (Cochran et al., 2017; Dilley, Simmons, Boysun, Pizacani, & Stark, 2010; Fredriksen-Goldsen et al., 2014; Luke & Goodrich, 2015a; Thorne et al., 2018). One such study conducted by Grella, Greenwell, Mays, and Cochran (2009) reported that LGBTQ* persons experiencing mental health-related issues sought mental health or substance-use services within the last year at a rate of 48.5%, while their counterparts sought the same services at a rate of 22.5%. Further, several authors have argued that the multiple forms of discrimination experienced by LGBTQ* persons are linked to increased mental health issues, which can begin to explain LGBTQ* persons’ disproportionate need for mental health services (Cochran et al., 2017; Thorne et al., 2018).

Given the high rates of discrimination and mental health concerns of LGBTQ* persons (Cochran et al., 2017; Thorne et al., 2018), it is concerning that counselor education has continued to overlook supervision as a means to increase LGBTQ* related multicultural competence and has instead primarily relied upon didactic training methods in isolated content courses of short duration to educate counselors on the needs of clients who may identify as LGBTQ* (Jennings, 2014; Luke, Goodrich, & Scarborough, 2011). As such, this article builds upon the use of ST in supervision (Ankestein et al., 2014; Markos et al., 2008; Paone et al., 2015; Stark et al., 2011), as ST offers a critical opportunity to redress the gaps in counselor education (Stark & Frels, 2014). Creative arts interventions in general, and ST in particular, have been lauded as offering supervisors a complementary right-brain and kinesthetic means (Stark & Frels, 2014) to creatively and experientially work with supervisees to match their developmental needs (Mullen et al., 2007). As a creative and experiential intervention, ST offers supervisors opportunities to select learning activities that differentially respond to varied developmental needs of the supervisee (Ankestein et al., 2014; Carnes-Holt et al., 2014; Paone et al., 2015) working with clients across the LGBTQ* communities (Goodrich & Luke, 2015).

While supervision has long been recognized as the signature pedagogy for training counselors broadly (Bernard & Goodyear, 2013), more recently supervision has been acknowledged as an effective means to develop counselor LGBTQ* competence and ally development specifically (Luke & Goodrich, 2015a; Moe, Perera-Diltz, & Sepulveda, 2014). Interestingly, over the past decade there has been more focus on the needs of LGBTQ* clients in the counselor education literature and increased incorporation of creative art approaches (Bernard & Luke, 2015; Inman & Kreider, 2013; Soheilian, Inman, Klinger, Isenberg, & Kulp, 2014), but there is minimal extant literature that combines the two.

In the section that follows, the model for LGBTQ* responsive supervision (Goodrich & Luke, 2011; Luke & Goodrich, 2012, 2013, 2015a, 2015b, 2017) and the creative arts framework identified by Stark and Frels (2014) are synthesized to illustrate how ST can be used in the supervision of counselors working with LGBTQ* clients. Similar to how Guiâˆ”frida (2015) described constructivist approaches...
to supervision as offering a means for supervisor and supervisee to co-construct the supervisory processes and meanings, what follows includes a description of the types of materials needed for ST in supervision (Garrett, 2013) and how the supervisor can broach supervisees to engage in this creative approach related to their work with LGBTQ* clients (Goodrich & Luke, 2015; Luke & Goodrich, 2015a). This model will be followed by a description of how supervisors can co-construct the use of ST as a creative and expressive supervisory intervention (Carnes-Holt et al., 2014; Graham et al., 2014) to demonstrate ways in which the supervisee might use ST with LGBTQ* clients (Anekstein et al., 2014; Markos et al., 2008; Paone et al., 2015). Finally, there will be a discussion of how supervisors can facilitate supervisees’ transfer of the creative and experiential learning into their clinical practices, including post-supervisory extensions (Guiffrida, 2015) that hold particular salience for counselors working with clients who identify as LGBTQ* (Goodrich & Luke, 2015).

**LGBTQ* Responsive Sand Tray**

To address earlier identified purposes, the LGBTQ* Responsive Sand Tray approach in supervision is proposed as a means to assist supervisors and counselor educators in creatively and experientially supporting counselors’ work with LGBTQ* clients with differing affectional, gender, and sexual identities. As such, the LGBTQ* Responsive Sand Tray approach integrates transtheoretical LGBTQ* responsive supervision models (Goodrich & Luke, 2009; Luke & Goodrich, 2012, 2013, 2015a, 2015b, 2017) and the four stages of ST work identified by Stark and Frels (2014). Each framework provides a transtheoretical, concrete, pragmatic, and flexible approach; thus, they are theoretically compatible.

The transtheoretical LGBTQ* responsive supervision models developed by Luke and Goodrich were constructed through the integration of multiple theories, models, and frameworks (Goodrich & Luke, 2011; Luke & Goodrich, 2013; Miller & Luke, 2018), such as Group Systems Theory (Agazarian, 1997, 2001), the Discrimination Model (Bernard, 1979, 1997; Rubel & Okech, 2006), and multicultural frameworks and competencies (Atieno Okech & Rubel, 2007; Sue, Arredondo, & McDavis, 1992). As a result, the transtheoretical LGBTQ* responsive supervision models included points of entry for individuals and groups (i.e., intrapersonal, interpersonal, group-as-whole, supra-group), multicultural and LGBTQ* foci (i.e., knowledge, awareness, skills), and the supervisory role (i.e., teacher, counselor, consultant; Goodrich & Luke, 2011; Luke & Goodrich, 2013; Miller & Luke, 2018). The points of entry, multicultural and LGBTQ* foci, and supervisory roles were identified as an ideal systematic framework to assist individuals and groups in their ability to better serve the needs of LGBTQ* persons, as there was a gap in the supervision literature (Luke & Goodrich, 2013; Miller & Luke, 2018).

For instance, depending on the supervisory or educational context and the needs of students, supervisees, and/or clients, this framework provides a concrete structure to support supervisors and counselor educators in ensuring their students or supervisees can adequately meet the needs of LGBTQ* persons (Goodrich & Luke, 2011; Luke & Goodrich, 2013; Miller & Luke, 2018), whether by addressing their biases, lack of LGBTQ* knowledge or skills, countertransference, or various points of entry. Such issues or growth edges can cover a plethora of issues, such as preconceived notions of LGBTQ* dating, sexual relationships and intimacy, or norms; the intersections of gender identity, affectational orientation, and spiritual and religious identity; or the oppressive, homophobic, sexist, transphobic, and hegemonic experiences that impact LGBTQ* persons’ overall wellness, mental health, and safety (Cavanaugh & Peters, 2019; Farmer & Byrd, 2015; Goodrich & Luke, 2015; Thorne et al., 2018).

Accordingly, the transtheoretical LGBTQ* responsive supervision models (Goodrich & Luke, 2009, 2011; Luke & Goodrich, 2012, 2013, 2015a, 2015b, 2017) and the four stages of ST work identified by Stark and Frels (2014) have been combined to expand the ST and supervision literature aimed at fostering LGBTQ* competence, as they are purported to be pragmatic and flexible models. Additionally, given that the models developed by Goodrich and Luke (2011) and Luke and Goodrich (2012, 2013, 2015a, 2015b, 2017) were focused on expanding counselors’ abilities to serve LGBTQ* persons as well as the various concerns presented by LGBTQ* persons, these models provided an LGBTQ* centered framework. Unlike other LGBTQ* oriented supervision frameworks or models, such as the Integrative Affirmative Supervision Model (Halpert, Reinhardt, & Toohey, 2007) or the Queer People of Color Resilience-Based Model of Supervision (Chun & Singh, 2010), Goodrich and Luke (2011) and Luke and Goodrich (2012, 2013, 2015a, 2015b, 2017) models were developed for individual and group supervision; allot for various intersecting affectational orientations, gender identities, and sexualities; have been examined empirically; are pragmatic in nature; and can be used across different counseling and supervision theories (Luke & Goodrich, 2013; Miller & Luke, 2018). Thus, they arguably provide an ideal platform for LGBTQ* Responsive Sand Tray.

As a result, the authors purport that the LGBTQ* Responsive Sand Tray approach in supervision can provide supervisors with a temporal, creative arts process to better meet the needs of counselors working with LGBTQ* clients. Although the LGBTQ* Responsive Sand Tray approach is flexible enough to use in both individual or group supervision, the group context offers unique and additive benefits, such as developing a space in which group members are encour-
aged to be empathic; share their lived experiences, insights, and knowledge; promote interpersonal learning; and provide and receive feedback from fellow group members (Goodrich & Luke, 2015; Swank & Lenes, 2013). It is expected that through the creative and experiential approach, counselors will have sensitivity to the needs of their LGBTQ+ clients, greater awareness of ways in which their own worldview impacts their counseling, and more developed skills to provide culturally competent services.

Phases

The first step in using the LGBTQ+ Responsive Sand Tray approach in supervision involves what Stark and Frels (2014) identified as temporal phases of the ST process. In the initial introduction phase, the supervisor discusses the purposes and process of ST work and invites the supervisee to consider their interest and motivation for use. In this phase, the supervisor shares some composite case examples of the ways in which ST work can take place and how and why the supervisor believes that it will be useful with the supervisee in their work with LGBTQ+ clients in particular. The supervisor may wish to facilitate the supervisee’s exploration of the ST materials before ascertaining whether or not the supervisee is ready to proceed. Stark and Frels (2014) label the second step as the building phase, where the supervisor provides free range for the supervisee to reflect upon their work with the LGBTQ+ client and represent an aspect in the sand tray. During this phase, the supervisor observes and accompanies the supervisee in exploring and selecting from the miniatures. The purpose of this phase is for the supervisee to construct their sand tray; in doing so, the supervisee is experientially and creatively representing aspects of their counseling with the LGBTQ+ client.

Next, in the experiencing phase, the supervisee is reflecting upon and making meaning of their sand tray. During this phase, the supervisee may develop increased awareness, insight, and an interpretation of themselves, their client, the counseling relationship, or the supervisory experience. In the final connecting phase, the supervisee can transfer the knowledge across the earlier phases to their future work with the LGBTQ+ client. Just as counselors may support clients in applying awareness, knowledge, or skills developed in counseling to other aspects of their functioning, so too can supervisors support counselors in applying the same to future work.

Focus

Across any of the phases of ST work, the supervisor must decide on the area of supervisee multicultural competence on which to focus, awareness, knowledge, or skills (Sue et al., 1992). Although a supervisor can likely begin with any one area of focus and sequentially move to another, others have suggested that supervisees benefit from clarity and transparency about the specific focus at any given time. Said another way, Bernard (1997) cautioned the supervisor about sliding across focus areas, starting to address one focus and without explicitly noting, shifting to another focus. Bernard suggested that this is unnecessarily confusing to the supervisee. Thus, it is recommended that the supervisor intentionally and transparently shift focus areas in response to the supervisee’s perceived needs in a sequential manner (Luke & Bernard, 2006).

Roles

The final step in navigating the LGBTQ+ Responsive Sand Tray approach in supervision involves the supervisor deciding on the role from which the supervisory intervention will be delivered, from the teacher, counselor, or consultant roles (Bernard, 1979). Luke and Bernard (2006) noted that supervisors may have a theoretical or stylistic preference for specific roles, and supervisees may similarly have a preferred role through which they receive feedback or instruction (Bernard & Goodyear, 2013). That said, research has indicated that supervisor flexibility in intervening across supervisory roles is associated with better supervision outcomes (Falender & Shafranske, 2004; Ladany, Marotta, & Muse-Burke, 2001) and that supervisor role can influence subsequent supervisee focus (Stenack & Dye, 1982).

Case Example

Leah is a master’s student and intern at a community counseling agency in a city just 20 minutes from where she lives. She is in her last semester of her studies as a clinic mental health counselor and currently enrolled in an internship course where she has the opportunity to present her cases, videos of her counseling sessions, seek additional supervision, and consult with her peers and professor. Leah is a 26-year-old Caucasian individual who identifies as cisgender, female, monosexual, and Lesbian. Leah has been “out of the closet” since she was 16 years old and feels quite connected to the LGBTQ+ community. Leah grew up in a community and household that was LGBTQ+ affirming, sex-positive, agnostic, and encouraged individual identity exploration.

Leah has recently been given a few additional clients because she is hoping to build her caseload in hopes of finishing her program hours. Through this process, she has recently started seeing an 18-year-old LatinX individual who identifies as a cisgender male and is beginning to identify himself as a guy who likes guys. Leah’s client also belongs to a community and household that is less affirming of the LGBTQ+ community, Catholic, and values the concept familismo. In her internship course, Leah recently presented a tape and her body of work with this client whom she had seen for a total of four sessions. Leah identified her theoretical orientation, case conceptualization, and identified how she would like assistance from the professor and class. Leah stated that
she feels well connected to this client and that she has observed many similarities between their lived experiences, as she stated, "I remember being in the same situation and experiencing the exact same things at his age." Because of her felt similarities, Leah reported disclosing during her second session with her client that she identifies as Lesbian.

Since the disclosing of her affectional orientation, the client has begun to ask many questions about her lived experiences as a Lesbian woman, her journey exploring same-gender sexual and intimate relationships, and how her family and community handled her affectional orientation. As a result, Leah has felt some dissonance because she has wanted to use more self-disclosure in session; however, she now realizes that her disclosure might not have been in the best interest of the client, nor is it the correct use of her conceptualization of self-disclosure. Although Leah did not believe that his request was unreasonable or harmful, she experienced some internal hesitation, but was not certain as to why she was experiencing hesitation. Nonetheless, Leah shared her struggle of whether to share more or keep reflecting the client’s desire to have a piece of her, the counseling session, and the experience of another LGBTQ* individual.

Leah presented this information, a 20-minute segment of her work with this client, and there was some time for group supervision discussion. Within the internship course, there are six students, a doctoral-level teaching assistant, and a professor. Her internship professor Dr. Bloom identifies as a 58-year-old Black heterosexual woman. Dr. Bloom has acknowledged some of the intrapersonal struggles that Leah has identified during class and has invited Leah to partake in the use of ST as a supervisory intervention, while the class observes the process with the teaching assistant. Thus, Dr. Bloom decided to begin with an intrapersonal point of entry.

Dr. Bloom explains the utility and process of ST, the ST framework, and past student/supervisee experiences, while providing Leah with some time to reflect on her work with this client. Afterwards, Dr. Bloom invites Leah to create a ST focused on her dissonance with sharing her experiences and narrative as Lesbian woman with her client. After having some time to reflect, Dr. Bloom provides Leah with some space to select miniatures that represent her dissonance related to sharing more about her LGBTQ* experiences with the client who identifies as a guy who likes guys. Leah begins to select miniatures and slowly places them within the sand tray as Dr. Bloom observes and accompanies Leah in the process. Leah draws a Venn diagram in the sand and dedicates one circle to her client’s experiences and narratives, one for herself, and one for what she believes they share.

Leah takes much time in her selections of the miniatures as well as her placement of them within the sand. As Leah continues to select and place miniatures, Dr. Bloom verbalizes her observations of her student. During this process, Leah attempts to make meaning and reflect on her experience and process of using the ST as a representation of her with her client. Dr. Bloom sits with Leah but does not critique, analyze, or provide her supervisee with solutions. Instead, Dr. Bloom is assisting Leah in her process of creating a tray that engenders her own self-reflection and meaning making.

Leah slowly begins to become more intense in her interactions with the ST and with her professor. After a few more minutes pass, Leah releases a deep sigh and reports to Dr. Bloom that she believes she is finished and no longer feels torn; she knows what she feels now. Leah further discloses that she did not have the same experience as her client, and even though she wanted him to have a similar support system as she once had, she recognizes that their support systems and lived experiences are different. Dr. Bloom and Leah related this experience, and new insight towards future movement with the client.

For instance, given that Dr. Bloom was cognizant of Leah’s current state of LGBTQ* awareness, knowledge, and skills, she decided to use the role of counselor to process Leah’s missed awareness regarding how she and her client differ in many ways, such as faith, family-community relationships and values, affectional identity, gender identity, and racial identity. Dr. Bloom also opened up the ST to the rest of the group, and one student reflected that Leah reported through her Venn diagram circles and figures that she was in a relationship and sexually active at 17 years old, while her client reported liking men, but was uncertain of his comfortability engaging in anything beyond kissing and holding hands with another man. Dr. Bloom also facilitated other interpersonal and group-as-whole interactions with Leah and the ST. These interactions assisted Leah and Dr. Bloom in further exploring how Leah can use this experience to intentionally provide more culturally responsive, socially just, and effective services to this client and other future LGBTQ* clients and issues (Luke & Goodrich, 2015a, 2015b).

**Discussion**

As noted in the case example, Dr. Bloom acknowledged and reflected on some of Leah’s intrapersonal struggles she observed in Leah’s class presentation and tape of her clinical work. As a result, Dr. Bloom intentionally began the first step (Stark & Frels, 2014) of the LGBTQ* Responsive Sand Tray by inviting Leah to partake in ST, in order to explore her conceptualizations and personalizations that were influencing her clinical work with her client. Dr. Bloom shared her rationale, framework, and invited Leah to participate in the ST. Dr. Bloom also socialized Leah into the ST modality and normalized some potential reactions and/or types of experiences. Other questions and prompts that could be used within this step include the following:

- It is not unusual for supervisees to have mixed reactions to their initial use of ST. What is happening for you (Leah)? What is happening for you (class)?
Dr. Bloom enacted the second step (Stark & Frels, 2014), as she provided Leah with free range to reflect upon her work and experience with her LGBTQ* student. Although some supervisors prefer a directive approach (Garrett, 2015b, 2016) that includes analysis, notice that Dr. Bloom did not provide Leah with any interpretations or critiques here, just her observations of Leah and what was occurring. Other process observations or prompts that could be used within the second step include the following:

- Tracking type statements like, I’m noticing that you are placing X over there, and that you keep moving Y.
- What might you add that I haven’t addressed yet (to the class)?
- Reflection-type statements like, It looks like you’re concentrating/are feeling inhibited/are experiencing something right now. Would you like to discuss this?
- Hmm, I wonder what these objects might say to each other.
- I’m noticing that X is being brought up for me right now. I can’t help thinking that your client/peers might have a reaction to this ST too.

The third step (Stark & Frels, 2014) was enacted by Dr. Bloom, as she assisted Leah in developing further self-awareness, insight, and interpretation as to Leah, her client, multicultural and LGBTQ* foci, and their therapeutic relationship. During this process, Leah is able to begin to separate her own experiences from her client’s experiences as a guy who likes guys, which provided Leah with a sense of relief. Other questions and prompts that could be used within this step include the following:

- Now that we have discussed this a little, what else might you wish to add to/take away from the ST?
- Sometimes it can be helpful to journal about X, or to develop a dialogue between X and Y. What are your initial reactions to these ideas?
- Considering the X foci, how do you make meaning of the similarities and differences between your client’s LGBTQ* experiences and your own?
- If you were to give this ST a title, what might it be? Is there a fitting subtitle, or chapter names (Leah or the class)?

Following this, Dr. Bloom demonstrated the fourth step (Stark & Frels, 2014) where she began to further connect Leah’s meaning making and insights into her future work with LGBTQ* clients; thus, the transferring of knowledge and process into action piece began. This step is attending to Leah’s growth and development as a counselor. Other questions and prompts that could be used within this step to promote application or consolidation include the following:

- As you envision your future work with this client, what might a future ST contain?
- How will you address your client’s affectional orientation and sexuality concerns in your upcoming sessions? What resources might you need for this work or areas for ongoing consultation (Leah or class)?
- How might our supervisory relationship be represented in this ST (or others) as you continue to expand your multicultural competence with LGBTQ* clients?
- What objects from this ST do you hope to see represented in your next session with this client? In our future supervision? In your ongoing work with other LGBTQ* clients? What do you want to leave right here (Leah or the class)?

When looking at the focus (i.e., awareness, knowledge, skills; Sue et al., 1992), Dr. Bloom could have focused on several areas, but due to Leah’s reported intrapersonal struggles presented in class, Dr. Bloom attended to the awareness component. However, during the fourth step, she assisted Leah in moving beyond awareness, as she applied the awareness to knowledge and skills that could be cultivated in future sessions with LGBTQ* persons. Another important area within the case example was Dr. Bloom’s intentional selection of a role (i.e., teacher, counselor, consultant; Bernard, 1979, 1997). Given the focus and needs of Leah, Dr. Bloom began by using the role of counselor. This was demonstrated by her use of self, skills, and use of attending to Leah’s development. After she completed her work within this role, she transitions to the consultant role, as Leah and Dr. Bloom explore future directions, skills, and actions. Carnes-Holt et al. (2014) offered examples of ST supervisory interventions that can be used across the roles and foci within the Discrimination Model (Bernard, 1979, 1997).

Implications

Clients who identify as LGBTQ* experience higher rates of suicide, homelessness, bullying, educational obstacles, physical harm, and substance use than their heterosexual and
gender normative peers (Cavanaugh & Peters, 2019; Dank et al., 2013; Dilley et al., 2010; Fredriksen-Goldsen et al., 2014; Goodrich & Luke, 2015). These experiences and historical issues regarding mental health services for LGBTQ* individuals situate the importance for services, training, supervision, and ethical guidelines when working with the LGBTQ* population (ALGBTIC LGBQQIA Competencies Taskforce et al., 2013; Luke & Goodrich, 2015a; Moe et al., 2014; Troutman & Packer-Williams, 2014). Documented within the counseling literature is the need and ethical responsibility for supervisors to foster supervisees’ competence and ability to work and advocate for LGBTQ* clients (ALGBTIC LGBQQIA Competencies Taskforce et al., 2013; Goodrich & Luke, 2015; Loue & Parkinson, 2015; Moe et al., 2014; Troutman & Packer-Williams, 2014). In addition, counselor educators and supervisors utilizing ST must recognize that ST is a form of creative arts (Gladding, 2010), ergo, similar to the use of any supervisory intervention or framework, counselor educators and supervisors need to understand the limitations and ethics behind utilizing ST in supervision (Bernard & Goodyear, 2013; Stark & Frels, 2014).

Thus, despite its diverse benefits, this modality should be used with caution (Loue & Parkinson, 2015). Owing to the deeper reflective process (Stark & Frels, 2014), ST can often too blur the boundaries of supervision and counseling; it may go too deep too fast, and can cause harm by misinterpreting the art and themes (Anekstein et al., 2014; Isom et al., 2015; Stark & Frels, 2014). Moreover, it is crucial that supervisors have appropriate training and experience with ST, understand that the limits of confidentiality apply to produced artwork, and supervise the use of ST by supervisees (Carnes-Holt et al., 2014; Garrett, 2013; Stark & Frels, 2014; Stark et al., 2015). While researchers have indicated the benefits of ST (Markos et al., 2008; McCurdy & Owen, 2008), further research on ST in supervision is needed to understand the effectiveness and utility of ST as a creative arts intervention. As most research on ST to date is qualitative, and descriptive in nature, there is a need to begin examining ST processes and outcomes using quantitative measures as well. Further, this work would benefit from examining the efficacy of ST in fostering LGBTQ* competence for supervisees (Anekstein et al., 2014; Goodrich & Luke, 2015; Luke & Goodrich, 2015a; Paone et al., 2015).

Additionally, future scholarly writing and research can build upon this proposed framework to further address the dearth of creative arts and ST literature focused on developing counselors who are prepared to provide culturally responsive services to persons with diverse affective orientations, gender identities, and sexualities, especially the intersections of such identities across the lifespan. This is of the utmost importance, as LGBTQ* persons have unique experiences, needs, resiliencies, and mental health and wellness concerns, due to the intersections of these three specific identities (Cavanaugh & Peters, 2019; Goodrich & Luke, 2015). Furthermore, given the lack of counseling supervision literature and programmatic standards focused on these intersections, counselor educators and supervisors can use the LGBTQ* Responsive Sand Tray framework to proactively explore and address the intersections of affectional orientation, gender identity, and sexuality in clinical practice as well as courses, such as supervision, practicum and internship, human sexuality, multicultural and social justice, or group work (Cavanaugh & Peters, 2019; Goodrich & Luke, 2015; Zeglin et al., 2018).

Conclusion

The use of ST in supervision has various reported benefits for supervisees, such as processing difficult lived experiences and emotions around multiculturalism, cultivating personhood, developing awareness and reflexivity, and increasing empathy and understanding for clients’ experiences (Anekstein et al., 2014; Carnes-Holt et al., 2014; Garrett, 2013, 2015b, 2015a, 2016; Paone et al., 2015). The incorporation of ST within supervision provides a space for professional and multicultural development, as well as a space for transformative discovery, processing, and insight into the inner thoughts and feelings of supervisees (Paone et al., 2015; Stark et al., 2015). ST transcends the identified roles of supervisor, supervisee, and client, as it has been purported as a deep and meaningful approach for various populations and clinical settings (Anekstein et al., 2014; Graham et al., 2014; Isom et al., 2015; Stark & Frels, 2014). Thus, this framework and creative modality has much purported utility for the LGBTQ* community, particularly when preparing counselors and supervisees to explore and address the intersections of affectional orientation, gender identity, and sexuality within their clinical work.

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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 (Abdolrasulnia 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-
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 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.

**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).

**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 requests from me. Patricia was 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.

**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 motivations 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
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 trans-gendered (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*
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.

References


