Journal of Counseling Sexology & Sexual Wellness: Research, Practice, and Education

Volume 5 | Issue 2 Article 1

2024

Association for Counseling Sexology and Sexual Wellness Exemplary Practices for Counseling Sexology and Sexual Wellness

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Increasingly, the counseling profession recognizes the fundamental role of sexuality throughout peoples' lifespans, as sexual health is integral to overall physical and mental well-being, relationships and connections with others, and the safety of communities (World Health Organization [WHO], 2006). The Association of Counseling Sexology and Sexual Wellness (ACSSW) was formed to advance clinical training, professional standards, and scientific research in sexuality, becoming an affiliate of the American Counseling Association (ACA) in 2021 and a division of ACA in 2024. The core of 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" with the "goal of enhancing overall wellness" (ACSSW, 2019a, Mission section) in diverse communities.

As a step towards raising the standards of practice, education, and research in sexuality-related topics within counseling and related professions, we have developed these Exemplary Practices for Counseling Sexology and Sexuality Counseling. We intentionally chose the language of "exemplary practices" versus "competencies" to demonstrate the pluralistic, dynamic, and ever-evolving nature of sexuality. "Competencies" indicate standards that demonstrate sufficient knowledge or skills to perform a task, whereas "exemplary practices" denote repeated ways of being or behaving that serve as an effective model on which to base our own ways of being and actions. To provide context for the exemplary practices, we start by discussing the present need for such a model. Additionally, we review relevant definitions and explain our choice of language, theoretical foundations, and the structure of the exemplary practices. Like sexuality, this document is influenced by the interaction of historical, sociocultural, psychological, political, and other contextual factors. Hence, we encourage you to thoroughly read the introductory sections of this document to better understand the guiding principles in which the exemplary practices are based.

Need for the Exemplary Practices

Exploring sexuality and sexual wellness is not a new phenomenon; however, it was not always a conversation that people were willing to broach. Within the last decade, multiple events have occurred which launched more overt social discourse and direct advocacy regarding healthy sexual experiences. The #MeToo movement was founded in 2006 by Tarana Burke to increase awareness and support for survivors of sexual violence, particularly those from Black, Indigenous, and people of color (BIPOC) and lower socioeconomic status communities. In 2017, the #MeToo movement went viral on social media, prompting survivors around the world to share their stories of sexual assault and violence (me too., 2023, History & Inception section). Further, the COVID-19 pandemic brought increased awareness to intimate partner violence, which spiked internationally during lockdowns (Peitzmeier et al., 2022). Finally, within the U.S., topics regarding sexual health have been at the forefront of state and national legislation within the past several years (American Civil Liberties Union, 2023; Guttmacher Institute, 2023; Serchen et al., 2023). The centering of sexuality in politics has been used to drive increased partisan ideology, ultimately resulting in negative impacts on sexual health at both an individual and community level by restricting bodily autonomy, freedom of choice in sexual activities and identity expression, allowance of the freedom to change, and respect for others' beliefs and differences (Bergsvik et al., 2021).

The increased discourse on sexuality and related topics at both the national and global level has improved awareness, advocacy, solidarity, and mobilization, particularly around sexual violence; however, the enhanced focus on sexuality in public discourse also has led to increased sex negativity within social dialogue and global politics in attempts to maintain the status quo. As society navigates this complex landscape, it is

essential for counselors to promote informed, affirming discussions with clients and communities that challenge dominant (and often harmful) sociocultural narratives and foster a more inclusive understanding of sexuality. Further, prior research has highlighted the dearth of counseling sexology literature (Zeglin et al., 2017), as well as the invisibility and avoidance of sexuality in American society (Gunning et al., 2020). Counselors are ethically obligated to be advocates and contribute to positive, affirming, and beneficial change at sociocultural and institutional levels to foster sexual wellness. Within this work, we hope to expand existing worldviews to encompass the varied forms and motivating factors that make up the wholeness of sexual activity.

Aims and Scope

In this document, we present guidelines to enhance counseling practice in the areas of sex, sexuality, and sexual wellness. These guidelines aim to support counselors, mental health professionals, counselor educators, supervisors, institutions, and most importantly, clients and communities who seek to enhance their sexual wellness. The exemplary practices provide recommendations for counselors and other helping professionals to develop and deepen their comfort, awareness, self-reflection, knowledge, clinical skills, and advocacy skills in working with clients on sexuality-related topics. Additionally, the exemplary practices can be used as a training tool, as we provide a framework for counselor educators and supervisors to enrich counselor training in sexuality and sexuality counseling. We also intend these guidelines to be helpful to clients and consumers, as a means of developing a wellness-orientation towards sexuality within themselves, and to help locate providers who are using affirming and sex positive frameworks. Grounded in a social justice-oriented perspective, our guidelines advocate for systemic transformation and social action. We encourage mental health organizations, counseling programs, accrediting bodies, and other institutions to consider applying these guidelines in their respective settings. Our goal is to create systems that recognize sexuality as an essential part of the human experience, challenge sex-negativity, and promote sexual wellness in diverse communities.

Importance and Intentionality in Use of Language

In this section we explicitly discuss the use of language to embody the process and ongoing aspirational goals of addressing issues of sexuality and sexual wellness. As sex remains taboo, feelings of shame and secrecy pertaining to sexuality-related topics remain prevalent and are perpetuated through language and dominant discourses. We acknowledge how harm is inflicted through shame-based conceptualizations of sex and sexuality and offer a counternarrative grounded in research in which sex and sexuality are regarded not only as a common and natural aspect of the human experience, but also a source of pleasure, satisfaction, and freedom. We strive to center the diverse ways individuals experience and express sexuality, using intentional language to foster healthy and affirming discussions. In our critical reflection on these exemplary practices, we aim to encourage readers to engage with this document meaningfully. Our goal is to empower individuals and communities to take ownership of their sexual experiences and expression in an affirming instead of shameful manner.

We replace outcome-based language (i.e., competence) to align with our belief that very similar to the community of individuals across sexuality identities and praxis, we continue to grow, evolve, and learn. Thus, as we critically reflect on the process and outcome of these exemplary practices, we want to use intentional language that actively describes our hope of readers engaging with this document. We emphasize the ethic of cultural humility as a reminder of the importance of flexibility, decentering of the self, and recognizing power imbalances in providing affirming and respectful services. Central to cultural humility is critical introspection and commitment to learning, with the goal of mutually positive outcomes for providers and the communities they serve (Foronda, 2020). Hence, we will use terms such as culturally responsive, sensitive, critically aware, and affirming in lieu of competency throughout this document to recognize the growth orientation and process of cultural sensitivity and awareness in contrast to the expectation of achieving competency.

Additionally, we recognize that the terminology we choose to use throughout this document has its limitations, as language is imperfect in capturing the array of human experiences, ways of being, and is ever-changing. We use language to identify, construct, and define our multifaceted selves, and to understand others and the world around us. Language is also a site of contestation over truth, power, and meaning, and we all participate in and are constrained by the dominant oppressive discourses constructed throughout history (Sorrells, 2022). As we use words to think, give voice to our experiences, and communicate our understanding of the world and our ways of being with others, identity is inseparable from language (U. Anya, personal communication, June 6, 2023). Hence, a part of critical introspection is evaluating the language we use, in how our word choices either uphold and reinforce oppressive systems or serve to dismantle and transform those dominant systems that stigmatize and harm our communities. In the Glossary (see Appendix A), we describe the rationale and limitations of identity-based terminology we use throughout this document.

Primary Definitions

We utilize the World Health Organization's (WHO definition of sexuality for the Exemplary Practices, as their definition is based in a global context and the recognition of sexual health and wellness as a universal human right. Further, WHO's definition is one of the most widely used understandings of sexuality in the medical and mental health professions across the world. WHO defines 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, behaviors, practices, roles and relationships. While sexuality can include all 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. (WHO, 2006, Definitions section)

Sexuality is integral to interpersonal and intrapersonal well-being. Hence, sexual wellness is defined as:

The unique, subjective experience of physical, emotional, mental and social well-being in relation to sexuality essential to overall wellness. While sexual wellness can include the absence of disease, dysfunction, or infirmity, the holistic and subjective nature of sexual wellness extends beyond one's physical health status to include a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sensual experiences, free of coercion, discrimination, and violation. Sexual wellness encompasses diversity in both expression and influences, respecting, protecting, and fulfilling the sexual rights of all persons. (ACSSW, 2019b, What is Sexual Wellness? section)

Sexual wellness is grounded in healthy sexual behavior, ethical behavior that "balances sexual rights and sexual responsibilities" (Society for Advancement of Sexual Health, n.d., Vision of Sexual Health section). Six principles of healthy sexual behavior (American Association of Sexuality Educators, Counselors, and Therapists [AASECT], 2013; Darling & Mabe, 1989; Murray et al., 2017; Sexuality Information and Education Council of the United States [SIECUS], 2004; Southern, 2018) are as follows:

- Noncoercion: People should have the full ability to choose for themselves how, when, and whether to engage in sexual activities, and recognize that consent can change from moment to moment, encounter to encounter.
- Autonomy: People have the right to make bodily and sexual choices that benefit their sexual wellness. People are not objects to be controlled and should not be used for another's gratification.
- Responsibility: People should take accountability for sexual choices and behavior, avoid engaging in sexual practices that harm oneself and others, and be honest and not withhold information from their partners that diminishes their consent and autonomy to engage in sexual activities.
- Respect for others' beliefs and differences: People show regard for and do not force or coerce others to change their sexual beliefs, values, and variations.
- Allowance of the freedom to change: People acknowledge sexual flexibility and fluidity throughout the lifespan and promote others' autonomy to make bodily and sexual choices that benefit their sexual wellness.
- Reverse sex negativity: People engage in behaviors intended to reduce the shame, stigma, and pathologizing of sex and sexuality.

Additional guidelines for healthy sexual behavior include affirming sexual development as part of human development; appreciation of one's body; seeking information and education on sexuality-related topics; enjoying sexual pleasure; appropriately expressing love and intimacy to develop meaningful relationship; critical thinking and decision-making skills; open and direct communication with family, partners, and peers about sexuality; enjoying sexual feelings without always acting on them; and self-determination in conveying sexuality that is congruent with one's identities and values (SIECUS, 2004). Healthy sexual behaviors occur across a broad spectrum of sex and/or sexual practices that can be solo or partnered, with various goals or outcomes (e.g., pleasure, companionship, intimacy, self-expression, procreation), and multi-faceted mental and emotional impacts.

One of the primary goals of sexuality counseling, then, is to promote sexual wellness (ACSSW, 2019b) and healthy, ethical sexual behavior. Sexuality counseling is further defined as:

…a professional relationship that empowers diverse individuals, families, and groups to (a) increase comfort and awareness of sexuality and sexual experiences; (b) validate sexuality as a core aspect of the human experience that is actively included throughout the counseling process based on the needs of clients; (c) provide empirically-based education, guidance, and resources regarding sexual health concerns; (d) support clients as they navigate various influences on their sexuality in their goal toward overall wellness; (e) empower clients to express their sexuality with respect to their individual and other's sexual rights; and (f) promote sexual wellness. (ACSSW, 2019b, What is Sexuality Counseling? section)

It is important to note that sexuality counseling differs from sex therapy in a few ways. First, sexuality counseling is often short-term and focused on an immediate client concern, whereas sex therapy is often comprehensive, intensive, and may involve long-term psychotherapy (AASECT, n.d.). As such, sexuality counselors identify and make appropriate referrals for more intensive treatment when necessary. The P-LI-SS-IT Model can be used as a guide for sexuality counseling: P (permission) involves the counselor creating a comfortable and safe environment for clients to discuss sex and/or sexuality; LI (limited information) invites the counselor to correct misinformation or assumptions; and SS (specific suggestions) involves the counselor pragmatically assessing the issues and collaboratively developing appropriate goals and plans with the client (Annon, 1976). Sex therapists, however, provide all these strategies (P-LI-SS) and IT (intensive therapy). IT may involve the coexistence of other complex mental health concerns, inter/intrapersonal conflicts, or other major life issues. AASECT provides certification for Sex Therapists, Sexuality Counselors, and Sexuality Educators, and offers additional information about sex therapy in general (aasect.org).

Additional Terminology

When referencing marginalized populations throughout this document, we are referring to BIPOC communities, disabled persons, immigrants/non-residents, LGBTGEQIAP+ communities, and older adults, as well as individuals who are vulnerable or occupy marginalized spaces in other ways outside of race, ability status, age, immigrant status, sexual/affectional orientation and gender identity, such

as social class, socioeconomic status, partnership status, language preference, and religion/spirituality. Specific to the area of sexuality counseling, we also want to highlight sex workers as a marginalized population due to the stigmatization and criminalization of sex work in the U.S. as well as globally. Sex trafficking, which is distinct from sex work, refers to instances in which commercial sex is induced by force, fraud, or coercion, or in cases where the person induced to perform the sex act is under the age of 18 (U.S. Department of State, 2019). Sex trafficking is a crime of exploitation and a form of modern-day slavery (Centers for Disease Control and Prevention, 2022) that violates bodily autonomy and harms the health of individuals who are trafficked.

Additionally, we utilize terminology in the exemplary practices to refer to sexual subcultures and diverse relational bonds and configurations. Sexual subcultures are people or communities who engage in sexually divergent interests, desires, attractions, or behaviors towards persons, objects, or practices that deviate from normophilic sexual activities and diverge from heteronormative and monogamous forms of intimacy. Ethical non-monogamy (ENM) is an umbrella term for a relationship structure grounded in open communication and honesty where all involved parties consent to have romantic and/or sexual relationships that are not completely exclusive between two people. Sexual benefits, heightened intimacy, and sexual pleasure are often the focus of sexual interests and activities within sexual subcultures (Yates & Neuer-Colburn, 2019), as compared to the dominant script that the purpose of sexual activity is for procreation. Sexual subcultures include but are not limited to those practicing ENM; sexual paraphilias such as sadomasochism, fetishism, and cross-dressing; kink communities (or kink), including bondage, discipline, dominance, submission, and/or sadomasochism (BDSM), kinky sex, roleplay scenarios, sex games, fantasy, scenes, and fetishes; and virtual subcultures. Some individuals may view participation in sexual subcultures as an activity, behavior, or expression, whereas for others, involvement in sexual subcultures becomes a key aspect of their sexual identity (Litam & Speciale, 2019). Sexual paraphilias also fall under sexual subcultures, and counselors need to critically evaluate when sexually divergent behavior is healthy and ethical (e.g., sadism, masochism, cross-dressing, fetishism) to separate sexual divergence from the paraphilic disorders in the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition Text Revision (DSM-5-TR). A detailed review and definition of terms is included in Glossary A.

Theoretical Foundations for Exemplary Practices

We ground our exemplary practices in theoretical foundations that offer critical perspectives as counselors consider the role of sexology and sexual wellness in clients' daily lives. The theoretical frameworks were chosen for two purposes: to center the realities of communities whose identities render them invisible and to conceptualize the various factors that inform the ways communities make meaning of sexual identity, messages, and practices. Below, we provide a brief overview and explanation of each theory:

Critical Disability Theory (DisCrit): Seeks to understand the ways in which race, racism, classism, dis/ability, and ableism interact and frame the daily lived realities of people of color with dis/abilities. Identifies whiteness and ability as "property," in which economic benefits are granted to those who can claim goodness and normalcy through their identities as white and able bodied. Advocacy and accommodations for people labeled with dis/abilities are a result of interest convergence with White, middle class, and able-bodied people (Annamma et al., 2018; Connor et al., 2016).

Critical Gerontology Theory: Challenges the all-or-nothing stance that views older adults as either an impending burden and frail or as physically active, financially independent, and perpetually in their "prime." Promotes understanding older adults through a lens that encompasses the true variety of social, economic, emotional-intellectual, and physical differences present (Doheny & Jones, 2021; Flores-Sandoval & Kinsella, 2020; Leibing, 2020; vanDyk, 2014).

Critical Race Theory: White identity confers white privilege, leading many to view both as prized possessions that should be protected and maintained. Racism extends beyond the scope of intentional prejudices to include unintentional actions rooted in white supremacy and colonialism in post-colonial laws, policies, and institutions. Centers the voices of individuals belonging to oppressed and often silenced identity groups, as counternarratives serve as a form of enlightenment and an act of resistance against systemic oppression. Emphasizes the importance of society's privileged identity groups listening to and learning from the lived experiences of those marginalized and oppressed by societal systems (Albold & Miller-Dyce, 2016; Brown & Jackson, 2013; Crenshaw, 2010; Harris, 2012; McCoy, 2018; Salter & Haugen, 2017).

Feminist Theory: Grounded in a belief in human equality and the need to shift cultural paradigms related to gender, sex, sexuality, power, and privilege. Critiques how patriarchy is infused in culture, and calls counselors to continue to consider how sex and gender affect one's' identities and life functioning, in addition to class, ability, and others as important factors in determining one's power, privilege, or oppression (hooks, 2015; Sommers-Flanagan, 2015).

Queer Theory: Aims to deconstruct binary societal understandings of sexual/affectional orientation, gender, and other identities. Pervasive in society are the concepts of heteronormativity (the idea that being heterosexual is normal and good, while anything else is deviant and non-normative) and cisnormativity (the idea that being cisgender is normative, while being gender-expansive is not). Challenges established normative expectations, highlights the imbalance of power/oppression, and purports the importance of language, labels, and identities (Goodrich et al., 2016; Rowland & Cornell, 2021).

Sex Positivity: Conceptualizes sexuality as an evolving, varied, and pluralistic construct that is a natural part of the human experience. Grounded in multicultural, postmodern, feminist, and queer theories. Celebrates and affirms diverse sexual identities, practices, exploration, expression, and

intimate relationships, and emphasizes individual and community practice of openness, honesty, non-judgment, respect, freedom, agency, and liberation from negative sexual attitudes (Alexander, 2019; Burnes et al., 2017; Cruz et al., 2017; Mosher, 2017; Murray et al., 2017).

Relational-Cultural Theory: Purports that people grow through and toward relationships throughout their lifespan. Highlights interdependence as part of the human condition and mutual empathy and mutual empowerment as essential to healthy, growth fostering relationships (Jordan, 2000, 2017).

Trauma-Informed Care (TIC): Recognizes the prevalence of trauma and how trauma impacts people at both individual and systemic levels. Requires a systematic approach, at both a clinical and organizational level, towards supporting survivors' empowerment and healing. As with sexuality, trauma must be viewed through a sociocultural and ecological lens (Kimberg & Wheeler, 2019; Substance Abuse and Mental Health Service Administration [SAMHSA], 2014).

Foundational Principles of Critical Theories

The above theories share the following common foundational principles that influence our understanding of sexuality and sexual wellness, and hence are essential to an intersectional, culturally humble, and trauma-informed sexuality counseling practice that advances the well-being of diverse populations.

Intersectionality: Intersectionality rejects the assumption that discrimination and power can be understood by focusing on one identity at a time and considers how experiences of oppression and systemic inequity differs for people based on the multiple identities individuals possess. Counselors must consider how individuals who occupy various marginalized racial/ethnic identities, gender and sexual identities, class, and ability statuses may be more vulnerable to dehumanizing sexual stereotypes, state sanctioned sexual violation, discrimination, and sexual violence (Cho et al., 2013, Crenshaw, 1991).

Affirmation and Celebration: The role of affirmation requires that counselors move away from simply tolerating clients with diverse sexualities and practices, and intentionally move towards praxis that not only validates but celebrates the multifaceted ways individuals can experience their sexualities. A celebratory stance honors the existence of each person and the ways they are uniquely diverse, and uplifts the voices, customs, and histories of those groups that have been pushed to the margins or purposefully ignored. Recognizing every person as a gift to the world because of their individuality creates sustainable communities, liberates creativity and self-expression, and amplifies pleasure (McGuire, 2017; Thorpe et al., 2021).

Social Justice: Per the ACA Code of Ethics (2014), counselors are responsible for advocating to remove barriers that create harm for their clients. Critical theories promote social justice, advancing conceptualizations of clients beyond the microsystem to include the influence of communities, governments, institutions, culture, and history on peoples' lived experience in the present. A social justice stance analyzes how various discourses and systems impact sexuality as a human experience, either promoting or diminishing equity and fairness for all persons in relation to sexual wellness.

Critical Consciousness: A central element of liberation psychology, critical consciousness calls for counselors to deeply reflect on how they personally benefit from and maintain inequitable and unequal power structures, examining their own spaces of privilege and marginalization. A central task for counselors is building awareness of the various ways power is integral to the histories, interpersonal interactions, and intrapersonal experiences of people and communities. Counselors act out their values and beliefs in the counseling relationship; hence, counselors are subjective participants in co-constructing clients' knowledge and experiences (Butler & Byrne, 2008).

Critical History: Critical histories acknowledge how narratives are shaped by dominant groups seeking to maintain power, and calls counselors to challenge the ways knowledge is presented as power-neutral, biased, prejudiced and one-sided. As counselors explore counternarratives from historically marginalized communities, they can challenge misconceptions about historical events that influences the daily lived realities of clients, including their sexuality and sexual wellness. This iterative process involves actively amplifying the voices, histories, and sexualities of often-overlooked communities.

Contextual Influences: Counselors consider the role of family, culture, language, politics, environment, and history to better understand clients. Through capturing and analyzing contextual influences, counselors explore how clients make meaning and navigate their sexuality and sexual experiences over time.

Decolonization: The tenet of decolonization encourages clients to free their minds, bodies, and spirits by examining their current identities, the historical factors that have shaped them, and the cultural and power dynamics that contribute to their pain and suffering. Decolonizing counseling practice attends to power differentials in the counseling relationship and how theoretical approaches (including multicultural counseling) are often rooted in Eurocentric contexts that sustain abuses and perpetuate harm towards marginalized populations. Decolonizing practice promotes liberatory activism that dismantles dominant discourses that uphold oppression (Gorski & Goodman, 2015; Marsella, 2015; Smith, 2015).

Emphasis on Freedom and Liberation: A central aim of critical theories is emancipating oppressed minorities from the systemic forces and institutions that render their diverse lived experiences invalid. Transformation requires counselors both understand the ways in which systems of oppression create intrapsychic and material barriers, violence, terrorization to the lives of marginalized communities, while also developing new systems that offer freedom, empowerment, collaboration, and affirmation of diverse perspectives, his/her/t-stories and realities (Coleman, 2021). In terms of sexuality, the emphasis on freedom fosters exploration of sexual identity, practices, and

pleasure in contrast to dominant ideologies that invalidate diverse sexual expressions.

Respect for Varied Ways of Being: Critical theories challenge the idea that there is one "right" or "default" way of existing as human beings. The critical theories celebrate the varied, diverse, and evolving ways in which individuals experience themselves as sexual, romantic, affectionate, and whole human beings. Counselors must hold space for clients to explore relationships and ways of being different from their own.

Position Clients as Expert on their Identities and Lives: The critical theories value the lived wisdom of people experiencing oppression, instead of the intellectual, academic, "right" way to be and behave in society (Butler & Byrne, 2008). Counselors are not default experts and should refrain from telling clients, particularly those from marginalized backgrounds, what they need. Rather than situating ourselves as objective observers, counselors collaborate alongside clients and trust their inner strengths and resources to guide their journeys.

Trauma-Informed Lens: The critical theories recognize marginalization stress is a form of trauma, highlighting the impact of systemic discrimination on clients' lived experiences. Counselors should integrate a trauma-informed lens into their sexuality counseling practice, using evidence-based treatments that support trauma recovery with diverse clients. Counselors also should advocate to incorporate trauma-informed principles into organizational cultures, which can include cultivating sex positive and affirming environments, policies, partnerships, and educational opportunities.

Structure of Exemplary Practices

We utilized Zeglin et al. (2018)'s proposed human sexuality counseling competencies as a framework for the exemplary practice areas, with the addition of the foundational practice of increasing comfort with sexuality and sex-related topics, ongoing awareness of sexual values, and engaging in personal reflection to develop sensitivity to and affirmation of variations in human sexual behavior. Hence, the 12 exemplary practice areas in counseling sexology and sexual wellness are as follows:

1. Comfort, Awareness, & Personal Reflection
2. Ethical & Professional Behavior
3. History & Systems
4. Anatomy & Physiology
5. Sexual Identity
6. Sexual Development
7. Attractions
8. Intimacy & Interpersonal Relationships
9. Pleasure & Sexual Subcultures
10. Sexual Functioning
11. Mental Health & Medical Factors
12. Sexual Exploitation

Within each area, we identify practices in the following domains: a) attitudes, beliefs, & understanding of historical influences; b) knowledge; c) counseling skills; d) action and advocacy; and e) counselor education and supervision. We chose domains a-d to mirror the Multicultural and Social Justice Counseling Competencies (MCSJCC; Ratts et al., 2015), adding the domain of education and supervision to support counselor educators seeking to develop sexuality counseling responsiveness with their trainees. We conclude each practice area with evaluative questions intended to prompt critical introspection. We urge counselors to use the evaluative questions as a tool for ongoing introspection, in line with the foundational principle that exemplary practice in sexuality counseling involves an orientation towards self-reflexivity, openness to the experiences of others, fostering power-balanced relationships, and a lifelong commitment to learning. Finally, the Exemplary Practices should be utilized in conjunction with other ACA endorsed professional competencies, including but not limited to the MCSJCC (Ratts et al., 2015), the Competencies for Counseling LGBQQIA (Harper et al., 2013) and Transgender Clients (Burnes et al., 2010), the Disability-Related Counseling Competencies (Chapin et al., 2018), and the Advocacy Competencies (Toporek & Daniels, 2018).

Exemplary Practice Areas

1. Comfort, Awareness, & Personal Reflection

It is important that counselors regularly reflect on their own values and beliefs around sexuality, including their potential biases, so they can work towards increasing their own comfort and awareness regarding sex and sexuality. Establishing personal comfort in discussing sex and sexuality is essential to foster direct and honest discourses about these topics (Zeglin et al., 2018).

1a. Attitudes, Beliefs, & Understanding of Historical Influences

- Counselors critically examine their personal sexual values and beliefs and are aware of the factors influencing those beliefs and values.
- Counselors recognize and acknowledge how historical and cultural power dynamics influence sex and sexuality.
- Counselors acknowledge the role of intersectionality in conceptualizing experiences of sex and sexuality within clinical populations.

1b. Knowledge

- Counselors develop a sex-positive/sex-affirming framework.
- Counselors engage in continuing education to gain further insight and awareness of topics related to sex and sexuality.
- Counselors commit to openness of thought and scholarship related to sex and sexuality.
- Counselors stay abreast of current and evolving research and discourses on sex and sexuality.

1c. Counseling Skills

- Counselors demonstrate critical self-reflection.
- Counselors affirm the wide range of sexual identities, behaviors, expressions, and values.
- Counselors intentionally use language that is sex-positive and affirming of others.

- Counselors demonstrate the ability to consider varying points of view on controversial sexual topics.
- Counselors conceptualize sex and sexuality-related concerns in a non-pathologizing manner.

1d. Action & Advocacy

- Counselors hold space for future possibilities regarding sex and sexuality within the sociocultural context.
- Counselors apply a sex-positive and affirming framework to advocacy efforts.
- Counselors engage, participate in, and advance scholarship that promotes healthy and positive sexuality.
- Counselors remain aware of state and federal laws and regulations that impact the presentation, discussion, and existence of sexual identities and expressions.

1e. Counselor Education & Supervision

- Counselors seek continuing education, supervision, and consultation around sex and sexuality throughout their careers.
- Counselor educators and supervisors promote critical self-reflection and examination of biases with trainees.
- Counselor educators and supervisors foster sex-positivity and openness in their work with trainees.
- Counselor educators and supervisors specifically obtain and make available literature, interventions, and techniques within their courses that affirm the spectrum of sexual expression and identities.

Self-Evaluative Questions

1. What are my beliefs and values around sex and sexuality?
2. What are my biases around sex and sexuality? Where do these biases come from?
3. What is my comfort level around sex and sexuality, and discussing these topics with others? What influences my comfort level?

2. Ethical & Professional Behavior

Ethical and professional practices are central to providing effective sexuality counseling. Abiding by the American Counseling Association's (ACA) Code of Ethics (2014), as well as federal and state legal statutes, is foundational to all interactions with clients, supervisees, and students.

2a. Attitudes, Beliefs, & Historical Influences

- Counselors critically examine their personal values and beliefs about sex and sexuality and avoid imposing those values on clients.
- Counselors exhibit cultural sensitivity and trauma-informed perspectives to promote the dignity, autonomy, and well-being of clients' experiences of sex and sexuality.
- Counselors acknowledge and respect diverse sexualities through embodying nonjudgmental attitudes.
- Counselors provide an affirming, safe, and accepting atmosphere for clients to explore experiences of sex and sexuality.

2b. Knowledge

- Counselors stay apprised of shifts in culture and language and use a trauma-informed lens to promote sex positivity in counseling and avoid potential harm to clients.
- Counselors maintain awareness of ethical sexual behavior, including but not limited to noncoercion, autonomy, personal responsibility, respect for others' beliefs and differences, and allowance of the freedom to change.
- Counselors familiarize themselves with professional competencies related to working with diverse clients and sexuality-related issues.
- Counselors actively increase their knowledge base about sex and sexuality, while not practicing outside of the scope of their competency (ACA, 2014).

2c. Counseling Skills

- Counselors utilize language and verbiage that is affirming of varied sexualities and sexual experiences.
- Counselors purposefully avoid using harmful language, microaggressions, or any derogatory terminology.
- Counselors engage in ethical decision-making and actively seek consultation and supervision when experiencing conflicting values with clients.
- Counselors choose appropriate sexuality-related assessments based on the individual and unique needs of their clients and use cultural sensitivity and a trauma-informed lens in interpreting assessment results.

2d. Action & Advocacy

- Counselors actively work to reverse sex negativity by engaging in actions intended to reduce shame, stigma, and pathologizing of sex and sexuality.
- Counselors educate clients and communities about ethical and healthy sexual behaviors.
- Counselors lobby for ethical and equitable legislation that promotes the welfare and sexual wellness of diverse communities.
- Counselors engage in prevention and intervention efforts that are grounded in trauma-informed practices.

2e. Education & Supervision

- Counselor educators and supervisors model and prepare trainees on how to apply the principles of ethical sexual behavior in counseling.
- Counselor educators conduct sex and sexuality research that promotes the welfare and sexual wellness of participants through protecting their privacy, autonomy, and confidentiality.
- Counselor educators and supervisors model and facilitate using sex-positive language, broaching, and navigating discomfort around sex and sexuality-based topics.

Self-Evaluative Questions

1. What ethical and professional challenges have I experienced in exploring sex and sexuality-related topics with clients?
2. How do I (or would I) ethically navigate conflicting values with my clients?
3. What are actions I can take to reverse sex negativity and/or reduce shame, stigma, and pathologizing of sex and sexuality?

3. History & Systems

To decolonize sexuality and sexual wellness, counselors must first be aware of the roles of oppressive historical institutions centering societal power (i.e., white patriarchy, cisnormativity, heteronormativity, purity culture) and their influence on current conceptualizations of sexuality. Counselors critically examine ways in which dominant groups determine sexual norms and weaponize sex to further oppress marginalized groups, such as through the fetishization of BIPOC sexuality, preoccupation with genitalia of gender expansive folx (specifically trans individuals), the infantilization of older adult sexual expression, the denial of adolescent sexual rights, erasure of sexuality in disabled persons, and sexual exploitation of sex workers. Further, counselors should use a trauma-informed lens when working with clients experiencing the mental health consequences of colonized cultural and institutional messaging, values and customs pertaining to sex and sexuality.

3a. Attitudes, Beliefs, & Historical Influences

- Counselors critically examine the historical messages and values underpinning conceptualizations of sex and sexuality.
- Counselors consider the current conceptualizations of sexuality through an intersectionality-informed lens.
- Counselors consider the influences of oppressive systems in examining their own values related to sex and sexuality through a trauma-informed lens.
- Counselors critically reflect on the use of sex as a weapon of colonization and oppression towards individuals of marginalized identities.
- Counselors consider the systems and historical contexts that may shape clients' expressions and experiences of sex and sexuality.

3b. Knowledge

- Counselors seek continuing education regarding the decolonization of sexuality and sexual wellness.
- Counselors commit to learning about the history of diverse sexual identities, expressions, and conceptualizations of sexuality across cultures.
- Counselors seek to foster clients' knowledge of ways in which historical and/or oppressive values may be contributing to sexual expression that misaligns with clients' current sexuality.
- Counselors engage in scholarship to reverse sex negativity and unlearn internalized stigma towards sex and sexuality.
- Counselors engage with trauma-informed scholarship to inform their work with clients of diverse sexual identities and expressions.

3c. Counseling Skills

- Counselors foster a sex-positive, non-judgmental counseling relationship to enhance clients' exploration of their sexuality.
- Counselors use empirically supported, culturally sensitive, destigmatizing instruments to assess client concerns related to sex and sexuality.
- Counselors explore how clients' understanding of sex and sexuality are shaped by historical, cultural, and societal messages.
- Counselors avoid the pathologization (and re-pathologization) of clients' sex and sexuality-related concerns utilizing trauma informed care practices.

3d. Action & Advocacy

- Counselors engage in various levels of advocacy to foster clients' abilities to express their sexuality in a manner that allows for client autonomy.
- Counselors create instruments/assessments that are inclusive and affirming for individuals with diverse sexual identities, experiences, and expressions.
- Counselors advocate for the deconstruction of systems that foster sexual oppression and exploitation.
- Counselors offer opportunities for clients' exploration of sexuality identities, expressions and liberation.
- Counselors co-construct empowering conceptualizations of sex and sexuality with clients.

3e. Education & Supervision

- Counselor educators and supervisors provide sex-positive and affirming education and supervision to trainees.
- Counselor educators and supervisors foster trainees' abilities to deconstruct oppressive conceptualizations of sex and sexuality.
- Counselor educators and supervisors integrate expansive, empirically supported theories of sexuality and sexual wellness into coursework and supervision.
- Counselor educators and supervisors hold space for trainees to explore ways in which historical forms of oppression continue to shape current conceptualizations, expressions, and expectations regarding sex and sexuality.
- Counselor educators train supervisors to engage in critical conversations with supervisees regarding client concerns involving sex and sexuality from a trauma-informed lens.

Self-Evaluative Questions

1. How are my current beliefs and values pertaining to sex and sexuality shaped by historical, cultural, and societal messages?
2. In what ways am I currently challenging oppressive, historical values surrounding sex and sexuality?
3. How might historical and sociocultural messages around sex and sexuality inform my comfort level in discussing sexuality and sexual wellness concerns with clients?

4. Anatomy & Physiology

Having a basic knowledge of anatomy and physiology is central to better understand diverse clients' experiences of sex and sexuality throughout the lifespan. Having a healthy body contributes to sexual wellness. In addition to minimizing health risks, understanding unique anatomy and physiology can promote positive sexual functioning, enhance pleasure, and contribute to healthier lifestyles. It is also important for counselors to understand how medical trauma and stigmatization within the healthcare system can contribute to clients experiencing a negative relationship with their bodies and diminish their sexual wellness.

4a. Attitudes, Beliefs, & Historical Influences

- Counselors engage in appropriate self-reflection on their own feelings, experiences, and/or past trauma impact their relationship with their sexual anatomy and physiology, maintaining awareness of how their own experiences may impact the counseling relationship.
- Counselors develop awareness of historical and colloquial terms that may be used by clients to describe sexual anatomy and physiology.
- Counselors examine self and sociocultural biases that contribute to derogatory conceptualizations of sexual anatomy and physiology in marginalized populations.
- Counselors respect clients' bodily autonomy and decision-making regarding sexual anatomy and physiology.

4b. Knowledge

- Counselors have a basic understanding of human anatomy, including internal and external physiological structures (e.g., vulva, labia major and minor, uterus; or the glans, the frenulum, the scrotum).
- Counselors avoid binary assumptions related to sex and gender when considering clients' sexual health, wellness, and functioning.
- Counselors seek information about sexual anatomy and physiology from accurate and medically reputable sources, such as the National Library of Medicine (http://www.nlm.nih.gov/medlineplus/).
- Counselors develop understandings of sexual anatomy and physiology that are trauma-informed and applicable to diverse populations across the lifespan (e.g., gender affirming care for non-binary individuals).

4c. Counseling Skills

- Counselors accurately communicate in a developmentally appropriate and trauma-informed manner about the roles and functions of sexual anatomy and physiology with clients.
- Counselors rely on language used by their clients for identifying themselves and their sexual anatomy and physiology.
- Counselors promote sexual health and pleasure with differently abled clients by assisting with adaptation of sexual practices and behaviors to their unique circumstances.
- Counselors use medically reputable sources when providing psychoeducation to clients on sexual anatomy and physiology.
- Counselors interpret assessments related to physiological sexual functioning in a culturally sensitive, trauma-informed, and developmentally appropriate manner.

4d. Action & Advocacy

- Counselors empower clients with clear, inclusive, and valid information and feedback related to a clients' sexual anatomy and physiology.
- Counselors actively work to challenge derogatory conceptualizations of anatomy and physiology that contribute to marginalization, stigmatization, and fetishization.
- Counselors provide accurate, medically reputable, and anatomically correct information about sexual anatomy and physiology throughout the lifespan to clients and communities.
- Counselors create inclusive spaces within the healthcare system and educate other healthcare providers to prevent and reduce the occurrence of medical trauma for marginalized populations.
- Counselors lobby for legislation and policies that respect clients' bodily autonomy and decision-making regarding sexual anatomy and physiology.

4e. Education & Supervision

- Counselor educators and supervisors utilize inclusive, accurate, and reputable medical sources in sexuality counseling training.
- Counselor educators and supervisors model and promote positive and respectful discourses of sexual anatomy and physiology.
- Counselor educators and supervisors prepare trainees to provide culturally sensitive, trauma-informed, and developmentally appropriate psychoeducation on sexual anatomy and physiology to their clients.

Self-Evaluative Questions

1. What sexual anatomy and physiology-based topics am I comfortable discussing with my clients?
2. How can I increase my knowledge of sexual anatomy and physiology-based topics?
3. How may my understanding of sexual anatomy and physiology be culturally sensitive for diverse clients' (e.g.,

transgender and gender-expansive, disabled persons, children and/or older adults, BIPOC communities) experiences?

5. Sexual Identity

We define sexual identity broadly as a person's innermost sense of themselves as a sexual being, which influences how individuals self-identify within social groups. Sexual identity is often associated with sexual/affectional orientation. However, sexual identity is multifaceted and encompasses many dimensions of human sexuality, including sex assigned at birth, gender identity and expression, preferred attributes of sexual and romantic partners, physiological responses to stimuli, and sexual needs, values, behavior, and fantasies (Dillon et al., 2011; Savin-Williams, 2011).

5a. Attitudes, Beliefs, & Historical Influences

- Counselors critically reflect upon their personal values, biases, and beliefs about sexual identities and the origins of these biases.
- Counselors are aware of the ways in which their personal values, biases, and beliefs about sexual identities may impact their work with clients.
- Counselors are aware of how the media and sociopolitical culture influence client's perceptions of themselves and their sexual identities, and how sociocultural oppression can contribute to and/or exacerbate trauma.
- Counselors are aware of historical (and current) oppression and discrimination against clients with non-dominant sexual identities, gender identities, relationship configurations, or sexual interests.

5b. Knowledge

- Counselors are aware of the unique components that make up and the multifaceted nature of sexual identity.
- Counselors understand how having other marginalized intersections of identity and potential intersectionality of components that make up sexual identities impacts clients' lived experiences, especially in relation to trauma.
- Counselors understand the uniqueness and dynamic nature of sexual identities, which may vary over time.
- Counselors intentionally strive to increase their knowledge and understanding of diverse sexual identities.

5c. Counseling Skills

- Counselors respectfully and sensitively broach client sexual identities from a place of cultural humility.
- Counselors provide culturally sensitive and trauma-informed psychoeducation to clients about sexual identities.
- Counselors use the client's self-identified language to describe sexual identities.
- Counselors use affirming, validating, and empowering modalities, interventions, and language pertaining to sexual identities.

5d. Action & Advocacy

- Counselors advocate with and for clients and communities with non-dominant sexual identities to reduce barriers to affirming healthcare and eliminate ongoing systemic oppression.
- Counselors provide information about sexual identities to populations who may not have direct access to this information.
- Counselors remain current on legislation, policies, and practices at various systemic levels that oppress individuals with non-dominant sexual identities.
- Counselors work collaboratively and interdisciplinarily to advocate for individuals with non-dominant sexual identities.

5e. Education & Supervision

- Counselor educators and supervisors provide training and education regarding affirmative and empowering practices with individuals with non-dominant sexual identities.
- Counselor educators and supervisors prepare trainees to engage in advocacy efforts for individuals and communities with non-dominant sexual identities.
- Counselor educators and supervisors broach sexual identity in classrooms and supervision, fostering culturally sensitive and trauma-informed discussions with trainees.
- Counselor educators and supervisors infuse information pertaining to sexual identities across courses and fieldwork experiences.

Self-Evaluative Questions

1. How are my current beliefs and values pertaining to sexual identities shaped by historical and sociocultural contexts?
2. What are my experiences with my own sexual identity development and how does this influence my work with clients?
3. What am I doing and what more can I do to increase my awareness and understanding of non-dominant sexual identities?

6. Sexual Development

Sexual development includes physical changes as well as evolving sexual knowledge, sources of pleasure, preferences, and beliefs individuals hold throughout the lifespan. Counselors need to critically examine and possess substantial understanding and ability to address sexual development and potential concerns that clients may present.

6a. Attitudes, Beliefs, & Historical Influences

- Counselors critically reflect on their attitudes and beliefs towards the different approaches and conceptualizations of sexual development beyond traditional westernized models.
- Counselors hold space for examining clients' worldview or personal understanding (or lack thereof) of sexual development.
- Counselors challenge historical and sociocultural narratives that attempt to shape sexual development according to a specific agenda, recognizing how such narratives contribute to ongoing trauma for marginalized populations.

- Counselors actively demonstrate and engage in creating clinical spaces that invite diverse experiences and understandings of sexual development.

6b. Knowledge

- Counselors actively engage in research and purposely infuse current empirically supported scholarship on sexual development into clinical practice.
- Counselors collaborate with clients to integrate theory and culture to holistically understand sexual development, also considering the impact of trauma.
- Counselors utilize their knowledge to inform clients' conceptualizations and understanding of sexuality and sexual development.
- Counselors are open to and explore non-western and non-traditional understandings and expressions of sexual development (i.e., storytelling, poetry, dancing).
- Counselors actively seek to learn about a client's sexual knowledge, sources of pleasure, preferences, and beliefs without applying assumptions based on outside factors (i.e., perceived maturity, physical appearance, age, etc.)

6c. Counseling Skills

- Counselors practice ethically by maintaining appropriate proficiency and licensing or training to work with specific populations.
- Counselors integrate medically reputable and trauma-informed psychoeducation to inform clients/students of relevant information with regards to sexual development.
- Counselors utilize developmentally appropriate, culturally sensitive, trauma-informed language and resources to communicate about sex and sexuality development.
- Counselors are apprised of ways to practically apply knowledge of sexual development into counseling/mentoring sessions.

6d. Action & Advocacy

- Counselors actively participate in lobbying for legislation that mandates the inclusion of empirically supported holistic sexual development education.
- Counselors advocate for the inclusion of diverse experiences and perspectives of sexual development.
- Counselors provide information and resources about sexual development to the community and populations therein.
- Counselors work collaboratively and interdisciplinarily to advocate for individuals with expansive sexual development identities or experiences.

6e. Education & Supervision

- Counselor educators and supervisors actively engage in broaching trauma-informed conversations about affirming experiences of sexual development with trainees.
- Counselor educators and supervisors integrate conversations on expansive sexual identity concerns and knowledge with trainees.
- Counselor educators and supervisors provide supervision that challenges trainees to explore their personal values, biases, and beliefs about sexual development.
- Counselor educators and supervisors deconstruct educational materials and systems that do not utilize empirically supported scholarship.

Self-Evaluative Questions

1. How does my current understanding of sexual development assist or hinder me in supporting my clients?
2. What are the systemic, sociocultural, historical, and traumatic influences that impact how I conceptualize and explain sexual development?
3. What non-traditional, non-western models can I use to discuss, conceptualize, and explain sexual development to diverse identity groups?

7. Attractions

Attraction is a phenomenon that encompasses various types of desires and connections towards others, including aesthetic, affectional, intellectual, platonic, romantic, sensual, and sexual attractions. Attraction represents the complex spectrum of human interaction and emotional response, ranging from physical closeness and sexual intimacy to non-romantic bonds and friendships.

7a. Attitudes, Beliefs, & Historical Influences

- Counselors critically examine their own attitudes and beliefs towards various forms of attraction, including but not limited to aesthetic, affectional, intellectual, platonic, romantic, sensual, and sexual attractions.
- Counselors are aware of historical and cultural influences on their attitudes towards and beliefs about attraction.
- Counselors understand the impact of societal norms, media representations, and cultural narratives on the conceptualization of attraction, for both themselves and their clients.
- Counselors actively create clinical spaces that foster safety and acceptance for the varied forms of attractions.
- Counselors avoid assumptions about clients' descriptions and experiences of attraction when considering clients' sexual health, wellness, and functioning.

7b. Knowledge

- Counselors strive to possess a thorough understanding of the spectrum of attraction, recognizing that it extends beyond traditional binary notions of sexuality, including knowledge of asexual and aromantic spectrums, the fluidity of attraction, and the distinction between different types of attraction.
- Counselors familiarize themselves with current research on attraction, including psychological, biological, sociocultural, and historical factors that influence patterns of attraction.

- Counselors intentionally strive to increase their knowledge and understanding of how attraction might impact clients' lived experiences.
- Counselors develop knowledge about the intersections of attraction when considering clients' sexual health, pleasure, wellness, and functioning.

7c. Counseling Skills

- Counselors develop the ability to discuss topics of attraction openly and without judgment, using inclusive language that respects clients' experiences and identities, and fostering a safe space for exploration and understanding of one's attractions.
- Counselors address the complexities and challenges that clients may face regarding their attractions, including societal stigma, internalized negativity, trauma history, and relationship dynamics.
- Counselors use affirming and inclusive language and resources to communicate with clients about their experiences of attraction.
- Counselors practically apply knowledge and understanding of attraction to support clients in counseling sessions.

7d. Action & Advocacy

- Counselors advocate and lobby for the recognition and respect of all forms of attraction within societal, educational, and policy contexts.
- Counselors challenge stereotypes, biases, and misinformation about attraction.
- Counselors engage in community education and outreach to promote a broader understanding of diverse forms of attraction.
- Counselors support resources and community initiatives that are inclusive, affirming, and aim to reduce stigma and discrimination based on attraction.

7e. Education & Supervision

- Counselor educators and supervisors emphasize the importance of understanding attraction in its various forms in counselor training.
- Counselor educators and supervisors incorporate comprehensive training on attraction into counseling curricula, ensuring that future counselors are well-equipped to support clients in this area.
- Counselor educators and supervisors include reflective practices that encourage trainees to explore their own beliefs and attitudes towards attraction and how these may impact their counseling practice.
- Counselor educators and supervisors broach and integrate critical conversations on the diverse types of attractions with trainees.
- Counselor educators and supervisors foster trainees' abilities to deconstruct oppressive conceptualizations of the diverse forms of attraction.

Self-Evaluative Questions

1. How do my beliefs and attitudes about attraction influence my counseling practice? How am I providing a non-judgmental, inclusive space for clients to explore their experiences of attraction?
2. What steps am I taking to continually educate myself about the spectrum of attraction and the implications for counseling practice?
3. How can I better advocate for the recognition and acceptance of diverse forms of attraction within my community and professional networks?

8. Intimacy & Interpersonal Relationships

Sexuality is shaped by and expressed in intrapersonal and interpersonal interactions throughout the lifespan, namely through learning how to be intimate with and connect with ourselves and others. Sexuality and sexual expression are often facilitated through intimate connection with others, which in turn fosters empathy, interpersonal flexibility, and a healthy sense of self. Intimacy includes a broad range of interpersonal dynamics which are not limited to sex and sexuality.

8a. Attitudes, Beliefs, & Historical Influences

- Counselors have an expansive understanding of intimacy as encompassing emotional, physical, psychological, spiritual, and/or sexual experiences and interactions with oneself and/or others.
- Counselors consider how early caregiving or familial interactions, and trauma history influence their own attitudes, beliefs, and values about intimacy, sex, and sexuality.
- Counselors are mindful of sociocultural and historical influences that impact caregiving and familial dynamics and interpersonal relationships throughout the lifespan.
- Counselors are mindful of how sociocultural and historical messaging impacts and restricts the expression of intimacy and interpersonal interactions of marginalized groups.

8b. Knowledge

- Counselors actively obtain knowledge about attachment styles and how attachment is associated with intimacy, sexuality, and sexual behavior.
- Counselors seek to foster clients' knowledge of ways in which their familial, sociocultural, and/or historical interactions and trauma history may be contributing to how they express intimacy within intrapersonal and interpersonal relationships.
- Counselors explore their emotional self-awareness and self-regulation as it relates to intimacy and interpersonal interactions to inform therapeutic relationships with their clients.
- Counselors actively seek training in empirically supported and trauma-informed approaches to relational and family counseling.

8c. Counseling Skills

- Counselors actively develop skills in relational and family counseling.
- Counselors use culturally responsive and trauma-informed assessments and intake questions to effectively identify client's attachment styles, intrapersonal responses, and interpersonal interaction patterns.
- Counselors incorporate familial, sociocultural, and/or historical influences and trauma history in case conceptualizations when exploring how clients define and express intimacy.
- Counselors provide psychoeducation about and use interventions that enhance clients' emotional awareness and self-regulation as it relates to their experiences of intimacy and intrapersonal/interpersonal interactions.
- Counselors actively attend to and broach intrapersonal and interpersonal processes that clients demonstrate regarding intimacy and relationships.

8d. Action & Advocacy

- Counselors advocate and support preventative measures that educate youth on socio-emotional learning and teach families skills to develop secure attachment relationships.
- Counselors work collaboratively and interdisciplinarily with other health professionals to provide holistic and trauma-informed care to diverse familial structures throughout their lifespan, including supportive resources for parents and caregivers.
- Counselors actively lobby for legislation that eliminates barriers and increases resources for parents and caregivers to build healthy relationships with their children.

8e. Education & Supervision

- Counselor educators and supervisors infuse empirically supported and trauma-informed approaches to relational and family counseling throughout counselor training.
- Counselor educators and supervisors integrate conversations on attachment styles and developing healthy relationships into counselor training.
- Counselor educators and supervisors establish co-constructed and collaborative supervision relationships with supervisees and model healthy interpersonal dynamics and boundaries throughout supervision.
- Counselor educators and supervisors utilize supervision interventions (e.g., interpersonal process recall) that promote trainees' interpersonal and intrapersonal exploration as connected to trainees' professional development as counselors.

Self-Evaluative Questions

1. In general, how do you feel close and connected to yourself and/or others?
2. How do you communicate within your closest relationships about intimacy, sex, and sexuality?
3. How do the intrapersonal/interpersonal patterns you identified in questions 1 and 2 contribute to how you relate to clients in counseling? Contribute to how you discuss intimacy, sex, and sexuality with clients?

9. Pleasure & Sexual Subcultures

Central to understanding sexual pleasure and subcultures is the emphasis on consensual interactions, ensuring safety, and achieving personal satisfaction, pleasure, and fulfillment. We acknowledge the ways historical and sociocultural messages regarding sexual pleasure and subcultures have hinged on the purpose of sexuality as a function for procreation and for the enjoyment of others.

9a. Attitudes, Beliefs, & Historical Influences

- Counselors critically reflect on the consequences of dominant narratives of pleasure and sexual subcultures on clients and communities.
- Counselors lead with acceptance and non-judgement regarding expressions of pleasure and sexual subcultures.
- Counselors examine their biases and attitudes towards all consensual sexual subcultures, presentations, avenues, and functions of pleasure.
- Counselors understand how historical and sociocultural narratives influence personal worldviews of pleasure and sexual subcultures.

9b. Knowledge

- Counselors actively incorporate current literature to inform their understanding of pleasure-seeking and sexual subcultures, including divergent sexual desires, activities, and expressions.
- Counselors work collaboratively with clients to explore their own pleasure-seeking activities and experiences.
- Counselors explore non-traditional, non-dominant understandings of pleasure-seeking, sexual expressions, and subcultures.
- Counselors possess substantial understanding of sexual divergence to distinguish healthy, ethical sexual desires and behaviors from those that may cause distress for the individual and/or harm other persons and beings.

9c. Counseling Skills

- Counselors use current models of ethical sexual practices to conceptualize clients' pleasure seeking, sexual subcultures, and divergent sexual expressions and desires.
- Counselors integrate assessment of pleasure-seeking behaviors, sexual expressions, and sexual desires within clinical intake sessions.
- Counselors use appropriate techniques and questions to ascertain pleasure-seeking behaviors as a foundation for clinical goals.
- Counselors actively use and model unconditional positive regard and radical acceptance in understanding of sexual biases to create safe spaces in counseling.
- Counselors critically evaluate sexual divergence to discern healthy, ethical sexual desires and behaviors from

paraphilic disorders or other mental health diagnoses in the DSM-5-TR.

9d. Action & Advocacy

- Counselors support the liberation from prescribed narratives of pleasure and exploration towards an evolving understanding of diverse and consensual pleasure-seeking activities and sexual subcultures.
- Counselors actively lobby for legislation that mandates inclusivity and affirmation of varied consensual pleasure-seeking activities and expressions.
- Counselors work collaboratively and interdisciplinarily with other professionals to provide unbiased, affirming, holistic care and services.
- Counselors advocate within the community at large for the inclusion of diverse consensual pleasure-seeking experiences and sexual subcultures.

9e. Education & Supervision

- Counselor educators and supervisors infuse empirically supported approaches and practices regarding pleasure-seeking and sexual subcultures when working with counselor trainees.
- Counselor educators and supervisors initiate and integrate conversations on diverse pleasure-seeking practices and sexual subcultures in educating trainees.
- Counselor educators and supervisors provide supervision that challenges trainees to reflect on their personal values, bias, and beliefs surrounding diverse consensual pleasure-seeking behaviors and sexual subcultures.
- Counselor educators and supervisors ensure that trainees explore their interpersonal and intrapersonal development by operating from a sex-positive framework and broaching diverse sexual desires, consensual pleasure-seeking behaviors, and sexual subcultures.

Self-Evaluative Questions

1. What are the systemic, socio-cultural, and historical influences that impact how I conceptualize and explain pleasure-seeking practices and sexual subcultures?
2. What models and frameworks can I use to discuss, conceptualize, and explain pleasure seeking?
3. What knowledge do I hold related to consensual, pleasure-seeking practices and sexual subcultures? In what areas do I need to seek more information?

10. Sexual Functioning

The predominant framework for conceptualizing sexual functioning in Westernized society since the 1960s has been Masters and Johnson's (1966) sexual response cycle, which has influenced the definitions and associated symptoms of the Sexual Dysfunctions in the DSM-5-TR (APA, 2022). This commonly accepted understanding of sexual functioning is limited in its responsiveness to diverse sexual experiences, specifically for historically and currently oppressed communities, identities, and subcultures. Holistic and depathologizing conceptualizations of sexual functioning emphasize how the interactions between physiological, mental, emotional, spiritual, intrapersonal, and interpersonal responses impact sexual desire, arousal, lubrication, pleasure, orgasm, satisfaction, and intimacy.

10a. Attitudes, Beliefs, & Historical Influences

- Counselors consider the ways in which sexual functioning can be conceptualized through holistic, culturally responsive, trauma-informed and depathologizing frameworks.
- Counselors holistically understand sexual functioning as an interaction of physiological, mental, emotional, spiritual, and interpersonal responses.
- Counselors recognize how historical and sociocultural conceptualizations of sexual functioning have negatively impacted marginalized populations and/or pathologized healthy sexual behavior.
- Counselors acknowledge the ways in which their biases and contextual factors influence their own conceptualization of sexual functioning.

10b. Knowledge

- Counselors familiarize themselves with current, alternative, and sex positive conceptualizations of sexual functioning such as the incentive motivation model (Ågmo & Laan, 2022) or the intimacy-based female sexual response cycle (Basson, 2001).
- Counselors recognize the limitations of the DSM-5-TR in diagnosing sexuality-related disorders (e.g., genital/pelvic pain disorder emphasizes symptom association with sexual intercourse, although women experiencing genital/pelvic pain also encounter pain in a wide range of activities).
- Counselors are knowledgeable about the various ways in which individuals may experience and conceptualize their sexual functioning and its impact on their sexual pleasure.
- Counselors develop an understanding of how clients' trauma histories and familial, sociocultural, and historical influences can impact their sexual functioning.

10c. Counseling Skills

- Counselors conduct holistic assessments and evaluations to provide culturally sensitive, trauma-informed, and developmentally appropriate DSM-5-TR diagnoses for clients presenting with symptoms of sexual dysfunctions or related mental health disorders.
- Counselors develop holistic case conceptualizations that include clients' trauma histories and how familial, sociocultural, and historical influences impact their sexual functioning.
- Counselors discuss the benefits and limitations of diagnosing sexual dysfunctions and related mental health disorders with clients.
- Counselors broach topics related to sexuality and sexual functioning with clients in a sex positive manner.

10d. Action & Advocacy

- Counselors empower communities to expand their definition of healthy sexual functioning, promote opportunities for clients to articulate and explore what they find pleasurable, and assist with expanding their sexual repertoire.
- Counselors advocate for sex positive, trauma-informed, and holistic conceptualizations of sexual functioning, particularly in communities and cultures in which sexual functioning historically has been stigmatized or erased.
- Counselors advocate for holistic and sex positive assessment of sexual functioning and related sexual pleasure to depathologize the array of sexual responses individuals may experience.

10e. Education & Supervision

- Counselor educators and supervisors use destigmatized, depathologized, and sex positive language and frameworks to inform education and consultation on sexual functioning.
- Counselor educators and supervisors provide trainees with culturally responsive, trauma-informed, and holistic case conceptualizations of sexual functioning.
- Counselor educators and supervisors provide opportunities for trainees to critically examine and critique existing models of sexual functioning and diagnoses for their relevance and responsiveness to diverse populations and sexual experiences.

Self-Evaluative Questions

1. What factors currently influence my conceptualization of sexual functioning?
2. In what ways do my conceptualizations of sexual functioning perpetuate stigma and the pathologizing of diverse sexual experiences?
3. What is my understanding of the limitations of the DSM-5-TR diagnostic criteria related to sexual functioning?

11. Mental Health & Medical Factors

Mental and medical health are important aspects of sexual wellness. Clients' bodies may not always function in the ways in which they desire, which can negatively impact sexual fulfillment and pleasure. Further, the onset of health concerns, medical procedures, and negative interactions with the healthcare system can lead to medical trauma that may impact clients' sexual wellness and willingness to seek healthcare in the future. It is important that counselors do not overemphasize or stigmatize clients' sexual wellness based on mental health and medical health presentations. Counselors need to be intentional in using sex-positive, culturally responsive frameworks to address sexuality-related mental and medical health factors with clients of marginalized identities, inclusive of disabled and gender expansive persons.

11a. Attitudes, Beliefs, & Historical Influences

- Counselors understand the historical and social barriers to health and medicine within non-dominant, marginalized populations.
- Counselors are aware of and validate the mistrust of mental health and medical systems that clients of marginalized and oppressed identity groups may hold.
- Counselors are aware of societal stigma related to sexual health and wellness and how this impacts clients' lived experiences (e.g., HIV within LGBTGEQIAP+ and Black communities).
- Counselors support client autonomy in sex and sexual experiences (i.e., sex positivity) and avoid shaming or stigmatizing clients based on the intersections of their medical health and sexual desires.
- Counselors affirm clients who reject Westernized mental health and medical practices related to sex, sexuality, and sexual function and foster client's exploration of non-Westernized medical care.

11b. Knowledge

- Counselors understand how medical conditions, medical trauma, and other trauma affect the nervous, cardiovascular, and other systems, as well as how treatment side effects may impact clients' experience of sex and sexuality, including pleasure.
- Counselors understand the possible side-effects of medications used to treat mental and emotional disorders and how this impacts sex, sexual functioning, and pleasure (e.g., SSRIs can contribute to decreases in libido).
- Counselors understand the most common STIs (e.g., chlamydia, gonorrhea, syphilis, herpes, HPV), their treatment, and potential health implications later in life.
- Counselors are aware of the ways in which social stigma regarding sexual health might influence clients' desire to receive or not receive mental health and medical treatment.
- Counselors are aware of the ways in which the fetishization and hypersexualization of individuals of marginalized identities may manifest in mental health and medical practices or by providers (e.g., assuming individuals from certain identity groups engage in riskier sexual behaviors/practices).

11c. Counseling Skills

- Counselors use culturally responsive and trauma-informed interventions with clients of marginalized identities, particularly disabled persons, that promote their sexual agency.
- Counselors provide meaningful and accurate resources, psychoeducation, and information for appropriate treatment for sex-related mental and medical health (e.g., STIs, fertility, libido concerns connected to a mental health or medical diagnosis) (Centers for Disease Control, 2021).
- Counselors assess for sexual risk and/or sexually risky behaviors and provide appropriate information and options to clients to encourage healthy sexual practices (e.g., condoms, vaccines, dental dams, less-risky behaviors, abstinence).

- Counselors practice within the scope of their competency (ACA, 2014) and actively refer clients to affirming specialists in sexual care, sex therapy, gender-affirming care, and for medical consultations, as needed.

11d. Action & Advocacy

- Counselors advocate for equitable access to mental health and medical treatment for sexual health and wellness.
- Counselors advocate for improved access to sexual health information and treatment for clients of intersecting, marginalized, and non-dominant populations.
- Counselors work interdisciplinarily with other healthcare professionals to best support their clients' sexual wellness and prevent medical trauma.
- Counselors advocate for clients' rights to make mental health and medical decisions (e.g., contraception, abortion, vasectomy, tubal ligation, choice of medications, gender affirming care) related to their sexual functioning, health, and wellness.
- Counselors advocate against mental health and medical practices that are harmful to clients of marginalized and oppressed identities.

11e. Education & Supervision

- Counselor educators and supervisors include sexuality-based mental health and medical factors in case conceptualizations throughout the curriculum and fieldwork experiences.
- Counselor educators and supervisors operate from a sex-positive framework, ensuring that trainees are prepared to take affirming, holistic approaches to clients' intersecting, sexual, mental and medical health.
- Counselor educators and supervisors model affirmation of clients' autonomy in making mental health and medical decisions related to sex and sexuality.
- Counselor educators and supervisors prepare trainees to conceptualize clients' mental health, medical, and sexual wellness through a trauma-informed, decolonized, and non-binary lens, rejecting and critiquing oppressive dominant discourses (e.g., ableism, anti-Blackness, cissexism, Eurocentrism, heterosexism, sexism).

Self-Evaluative Questions

1. What are my own experiences with sexual health, including discussion of and/or treatment in mental health and medical settings?
2. What STIs do I need to learn more about to best serve my clients?
3. What are ways in which I'm conceptualizing clients' sexual health and wellness through an oppressive (e.g., ableist, anti-Black, cisnormative, Eurocentric, heteronormative, sexist) lens?

12. Sexual Exploitation

Sexual exploitation is characterized as actual or attempted abuse of a position of vulnerability and trust (WHO, 2021). We acknowledge that individuals with more power may abuse or harm individuals who lack power in some way (i.e., based on social position, privilege, access). As counseling professionals are mandated reporters, counselors should ensure client safety and adhere to ethical and legal guidelines upon discovery of acts of sexual exploitation, abuse and/or trafficking.

12a. Attitudes, Beliefs, & Historical Influences

- Counselors understand historical and social customs, messaging, and values that perpetuate sexual exploitation, abuse and/or trafficking.
- Counselors are aware of the devices of sexual exploitation and control as a means of dehumanization and terrorism towards BIPOC, LGBTGEQIAP+, and lower socioeconomic status communities.
- Counselors are aware of common behaviors and hallmarks of sexual exploitation, abuse and/or trafficking when working with clients and vulnerable populations at risk for sexual exploitation (i.e., children, older adults, disabled persons, gender expansive persons, immigrants, non-residents, displaced persons, persons from lower socioeconomic statuses, and sex workers).
- Counselors recognize and work to combat societal stigma related to people who have been victims of sexual exploitation, trafficking, and abuse.
- Counselors avoid blaming or shaming and are mindful of personal bias and beliefs about individuals who have experienced sexual exploitation, abuse or trafficking.

12b. Knowledge

- Counselors understand how sexual exploitation, abuse and/or trafficking can be proliferated within familial and community systems.
- Counselors examine risk factors for the perpetration of sexual exploitation, abuse and/or trafficking for vulnerable client populations.
- Counselors seek information and maintain awareness about how institutions and systems perpetuate sexual exploitation, abuse and/or trafficking (i.e., institutional betrayal) (Smith & Freyd, 2014).
- Counselors are aware of the ways in which the fetishization and hypersexualization of individuals of marginalized communities serve as a function of sexual exploitation and trafficking and/or facilitates abuse.
- Counselors support clients by understanding trauma-informed practices that mitigate the psychological, emotional, physiological, relational, and legal consequences of experiencing sexual exploitation, abuse and/or trafficking.
- Counselors understand that reporting sex trafficking often falls on the individual who is trafficked and can have repercussions such as loss of custody of children, imprisonment, legal charges, loss of employment, denial of community resources, and loss of social supports.

12c. Counseling Skills

- Counselors affirm and empower clients who have experienced sexual exploitation, abuse and/or trafficking.
- Counselors provide meaningful and accurate psychoeducation and information about sexual exploitation, abuse and/or trafficking and how these practices are proliferated through a trauma-informed lens.
- Counselors provide credible trauma-informed resources for preventing and addressing sexual exploitation, abuse, and/or trafficking.
- Counselors practice non-judgment and unconditional positive regard with clients who have experienced sexual exploitation, abuse and/or trafficking and clients who are at risk for perpetuating sexual exploitation and/or abuse (i.e., perpetrators of intimate partner violence, minor attracted persons).
- Counselors use culturally responsive and trauma-informed interventions and assessments for risk and experiences of sexual exploitation, abuse and/or trafficking when working with clients.

12d. Action & Advocacy

- Counselors advocate for programming and resources for survivors and perpetrators of sexual exploitation, abuse, and trafficking.
- Counselors advocate for preventative practices that promote healthy discussion and awareness regarding sexuality, relationships, and exploitation/abuse/trafficking.
- Counselors lobby for legislation that prevents and limits the perpetuation of sexual exploitation, abuse, and/or trafficking.
- Counselors advocate for the destigmatization and lessening of victim-blame within the process of disclosure and reporting of sexual exploitation, abuse, and/or trafficking.
- Counselors engage communities in establishing culturally affirming and trauma-informed survivor response systems outside of the traditional judicial system.

12e. Education & Supervision

- Counselor educators and supervisors operate from and exemplify a culturally affirming, trauma-informed, and non-judgmental stance regarding reports of sexual exploitation, abuse, and/or trafficking.
- Counselor educators and supervisors use trauma-informed, destigmatized, depathologized, and sex positive language and frameworks to inform education and conceptualizations of working with clients who have had or perpetrated experiences of sexual exploitation, abuse, and/or trafficking.
- Counselor educators and supervisors facilitate and engage trainees in conversations about sexual exploitation, abuse, and/or trafficking through a culturally affirming and trauma-informed lens.
- Counselor educators and supervisors educate and ensure trainees are aware of the signs, symptoms, and risk factors associated with sexual exploitation, abuse, and trafficking.
- Counselor educators and supervisors initiate discourse with trainees on the historical, social, and cultural processes that perpetuate and maintain sexual exploitation, abuse, and trafficking within society.

Self-Evaluative Questions

1. What are my current attitudes, biases, and preconceptions about individuals who have experienced and/or perpetrated sexual exploitation, abuse, and trafficking? How will I hold space for those whose experiences do not align with my values and beliefs?
2. What is my conceptualization of the differences between sex work and sex trafficking? How do my personal values or beliefs influence these conceptualizations?
3. In what ways, am I pathologizing behaviors and/or experiences clients have shared regarding sexual exploitation, abuse, and trafficking?

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Appendix A: Glossary of Terms

+: The plus sign is used along with the LGBTGEQIAP+ acronym to denote inclusivity of additional sexual, affectional, and gender expansive identities.

Ableism: Beliefs, behaviors, and/or systemic practices that devalue and discriminate against people with intellectual, physical, or psychological disabilities. Ableism is based on the belief that people with typical abilities are superior and people with disabilities need to be "cured" or "fixed."

Affectional/Romantic Orientation: Pattern of a person's affectional and romantic attraction towards the gender they want to partner with or fall in love with. Affectional/romantic orientation involves feelings of love toward another person and wanting to emotionally connect with another person, regardless of desire to be sexual with another person. Although affectional/romantic orientation can overlap with sexual orientation, they are not always the same; hence, people can have an affectional/romantic orientation distinct from their sexual orientation.

Affirming: Encouragement and validation towards clients' identities and lived experiences, communicating respect for and understanding of their varied sociocultural backgrounds and ways of being. Affirming counseling practices center clients' experiences and hold space for clients to explore themselves and how they want to relate to the world around them.

Aftercare: Often used to refer to showing care and support to one's partner after sex and, particularly, kinky play. However, aftercare can occur before, during, or after sex and play activities. Can involve cuddling, talking, non-sexual touch or massages, and other means of transitioning out of the erotic space.

Agender: An identity under the non-binary and gender expansive umbrella, which can be similar to the experience or identity of being gender neutral. Some agender people recognize agender as an identity within itself, while agender people self-identify as having no gender identity.

Acquired immunodeficiency syndrome (AIDS): The most severe stage of HIV infection, in which the immune system is badly damaged and the opportunities for infections and other serious illnesses are increased. Without treatment, people with AIDS typically only survive several years due to their compromised immune systems.

Allowance of the freedom to change: One of the six principles of healthy sexual behavior, in which people acknowledge sexual flexibility and fluidity throughout the lifespan and promote others' autonomy to make bodily and sexual choices that benefit their sexual wellness.

Anti-Blackness: Individual actions or behaviors and/or structural racism and oppression that minimizes and marginalizes Black humanity and Black people's participation in society. Anti-Blackness harms Black people through discrimination, violence, dehumanizing policies, segregation, police brutality, mass incarceration, and a general devaluing of Black lives and ways of being.

Aromantic: An affectional/romantic orientation generally characterized by not feeling affectional/romantic attraction or a desire for romance. Aromantic people may experience other types of attractions and feel satisfied with friendship and other non-romantic relationships. Aromantic people also may identify with other sexual orientations in addition to being aromantic. Also referred to as "aro" (ā-row).

Asexual: A person who experiences little to no sexual attraction and/or who has an absent to low desire for sexual activities. Asexual people may experience affectional and romantic attraction in intimate relationships and may identify with other affectional orientations. Also referred to as "ace."

Attraction: Attraction is both fluid and multi-dimensional, and encompasses various types of desires and connections towards others, including:

- **Aesthetic/objective attraction**: Finding someone visually appealing
- **Affectional/romantic attraction**: Feelings of love toward another person and wanting to emotionally connect with another person, regardless of desire to be sexual with another person
- **Emotional attraction**: Being emotionally and deeply connected to a person's depth and energy regardless of desire to be sexual with the person
- **Intellectual attraction:** Feeling connected to a person's intellect or the mutual intellectual connection with another person

- **Platonic attraction:** Feeling desire to form a friendship or deepen a connection with a specific individual, or to care or be cared for by someone, regardless of affectional/romantic or sexual attraction with that person
- **Sensual attraction**: Feeling attracted to and desiring physical touch with another person without desire to be sexually intimate
- **Sexual attraction**: Finding oneself aroused and/or desirous as a result of sexual energy toward a person, regardless of whether sexual interaction occurs

Autonomy: One of the six principles of healthy sexual behavior, in which people have the right to make bodily and sexual choices that benefit their sexual wellness. People are not objects to be controlled and should not be used for another's gratification

Black, Indigenous, and People of Color (BIPOC): An acronym used by the American Counseling Association when broadly describing the marginalization of people of color as compared to the white experience in the U.S. This term is used throughout the exemplary practices in alignment with the language used by the American Counseling Association and for readability due to societal familiarity with this term. Using this term, we aim to distinguish between the lived experiences of members of the global racial majority and those of white individuals. Limitations of this terminology are that it conflates all people of color together, does not distinguish how people of colors' experiences vary based on historical influences and their positionality in the dominant culture, and diminishes experiences of marginalized racial groups (e.g., Latino, Asian/Pacific Islander) that do not have their own letter in the acronym.

Bisexual: A person who has the capacity to form enduring physical, romantic, and/ or emotional attractions to those of the same gender or to those of another gender. People may experience this attraction in differing ways and degrees over their lifetime.

Bondage, discipline, dominance, submission, and/or sadomasochism (BDSM): Bondage and Discipline, Dominance and Submission, Sadism and Masochism. BDSM refers to a wide spectrum of activities and forms of interpersonal relationships. While not always overtly sexual in nature, the activities and relationships within a BDSM context are almost always eroticized by the participants in some fashion. Many of these practices fall outside of commonly held social norms regarding sexuality and human relationships.

Cisgender: Describes people whose gender identity and/or expression is aligned with the sex they were assigned at birth.

Cisnormativity: A pervasive and institutionalized system that naturalizes being cisgender as universal. Cisnormativity assumes that gender falls into two distinct and complementary categories along the binary of man and woman and is based in an essentialist view of gender (i.e., that gender is innate, stable, and fixed) vs. acknowledging the ways in which gender is a social construct.

Consensual non-monogamy: See definition for ethical non-monogamy.

Critical awareness: A strong understanding of and the ability to critically analyze underlying issues, contexts, and power dynamics in various situations; recognizing biases, injustices, and inequalities that exist within societal structures and considering the impact of one's actions and decisions on these dynamics.

Cultural humility: An approach to engagement across identity differences that acknowledges systems of oppression and experiences of resiliency and resistance, importance of flexibility, decentering of the self, and recognizing power imbalances in providing affirming and respectful services. Central to cultural humility is critical introspection and commitment to learning, with the goal of mutually positive outcomes for providers and the communities they serve.

Culturally responsive: A practice that recognizes, respects, and celebrates the cultural backgrounds, norms, and values of individuals and communities as a foundation for effective interaction and learning. Culturally responsive persons acknowledge and value diversity in cultural expressions and experiences.

Decolonization: the liberation of the mind, body, and spirit of clients through exploring who they currently are, the historical influences on how they have become the person they are today and exploring issues of power and cultural

determinants as contributors to their pain and suffering. This requires the deconstruction of colonial, Western systems of oppression and recentering indigenous identities, cultures, languages, and ways of being while fostering clients' autonomy and self-determination.

Deconstruction: Based on the philosophical ideas of Jacques Derrida, deconstruction is a method of critical analysis that challenges the relationship between language, meaning, and truth, taking apart and exploring the tensions, inconsistencies, and contradictions that underlie traditional social hierarchies. Within psychology, deconstruction critiques sociocultural beliefs, structures, and systems to uncover how hidden beliefs, biases, or cultural influences impact individuals' well-being, in addition to acknowledging how multiple "truths" exist simultaneously.

Disabled persons: Individuals who experience a range of physical, intellectual, cognitive, emotional, and other abilities that differ from those that are typically expected by the dominant society. We recognize that preferences in language vary, with some preferring person-first language (i.e., persons with disabilities) and others preferring identity-first language (i.e., disabled persons). Among the benefits of person-first language, such as "persons with disabilities" are the centering of the person and their humanity, rather than their interaction with their environment (Andrews et al., 2019). Conversely, identity-first language, such as "disabled persons" is destigmatizing and affirming, in that it reclaims the person's disability as an integral part of their identity, like their race, gender, or religion.

Ethical non-monogamy (ENM): Also known as **consensual non-monogamy** (CNM), ENM is an umbrella term for a relationship structure grounded in open communication and honesty where all involved parties consent to have romantic and/or sexual relationships that are not completely exclusive between two people. ENM follows the principles of healthy sexual behavior, with respect for all parties' consent, boundaries, and wishes. ENM can occur in many forms, including but not limited to polyamory, open relationships, monogamish relationships, relationship anarchy, swinging, polyfidelity, and polygamy.

Eurocentric: A form of ethnocentrism that regards European history and culture as superior and preeminent to all other cultures, excluding wider cultural and world views. The scope of Eurocentrism ranges from the European continent to the Western world, including North America and Australia, whose current cultures are heavily influenced by the colonization of Europeans.

Fertility: A person's ability to conceive children.

Fetish: An erotic or sexual desire towards a nongenital body part or non-living object.

Fetishism: Refers to one having a strong preference or interest in specific activities, tools, clothes, or fabrics, which may or may not include sexual feelings and behaviors associated with the fetish.

Fetishization: Sexual fascination with or making someone an object of sexual desire based on some aspect of their identity that is not inherently sexual.

Gay: Typically used to describe a man who has a pattern of affectional/romantic, emotional, physical, and/or sexual attractions to those of the same gender but may be a term used by nonbinary people or women.

Gender affirming care: Medical, mental health, social, and legal care that affirms a person's gender identity.

Gender dysphoria in the *DSM-5-TR*: The mental health diagnosis used to describe when a person experiences discomfort or distress due to an incongruence between their sex assigned at birth and their experienced or expressed gender.

Gender expansive/gender diverse: Used to describe people whose gender identities or expressions differ from sociocultural expectations attributed to their sex assigned at birth. Conveys a wider, more flexible range of gender identity and/or expression than typically associated with the binary gender system.

Gender expression: How one expresses or enacts one's gender in terms of names, dress, presentation of secondary sex characteristics (i.e., breasts, body hair, voice), mannerisms, speech, and/or behaviors. Gender expression may or may not correlate to one's gender identity.

Gender identity: A sense of one's felt, internal, and intrinsic self as a gendered being, which may or may not correspond with one's sex assigned at birth.

Genitalia: The reproductive organs and structures, both internal and external to the body.

Healthy sexual behavior: Ethical behavior that balances sexual rights and sexual responsibilities, grounded in the principles of noncoercion, autonomy, responsibility, respect for others' beliefs and differences, allowance of the freedom to change, and reversal of sex negativity.

Heteronormativity: The idea that being heterosexual is normal and good, while any other affectional and/or sexual orientations, desires, or behaviors are deviant and non-normative.

Human immunodeficiency virus (HIV): A virus that attacks the body's immune system that is the precursor to AIDS. Once people get HIV, they have the virus for life. Although there is currently no cure, HIV can be controlled with appropriate medical care. Through antiretroviral therapy, people with HIV can lead long and healthy lives. Appropriate medical care also helps prevent the spread of HIV to protect one's partners from transmission of the virus.

Hypersexualization: The attribution of or excessive focus on sexual or erotic characteristics or behaviors of someone or something to an inappropriate or extreme degree. Also, can include the attribution by the media or society to a product or behavior that is not intrinsically sexual. Hypersexualization can lead to objectification or fetishization of marginalized groups.

Immigrants/non-residents: People who immigrated to the U.S., particularly those who do not have legal residency or citizenship status, who have decreased access to mental health and other social services where they reside due to their residency status. Limitations of this terminology are that immigrants' experiences will vary widely based on the reasons they came to the U.S. (e.g., to pursue education vs. escaping violence and war), how they came to the U.S., their residency and/or citizenship status, language spoken, and lived experiences in their country of origin as well as where they settle in the U.S. Further, children and grandchildren of immigrant families also experience marginalization and acculturation difficulties, even though they may have citizenship status from being born in the U.S.

Infantilization: Treating an adult as a child, even though they are mentally, physically, socially, and intellectually capable of caring for themselves. Infantilization is a disrespectful and demeaning pattern of behavior and may occur more frequently towards older adults and people with disabilities.

Infertility: Difficulty or inability to conceive children after one year (or longer) of unprotected sex.

Intersex: A variation in sex characteristics (chromosomes, gonads, and/or genitals) that does not fit the typical definitions of female or male.

Intimacy: A broad range of interpersonal dynamics that facilitate closeness and connection with others, which can include but is not limited to sex and sexuality.

Kink communities: Also referred to as kink culture or simply "kink," is an umbrella term representative of people who experience sexually divergent desires and/or engage in sexually divergent practices, including bondage, discipline, dominance, submission, and/or sadomasochism (BDSM), kinky sex, role-play scenarios, sex games, fantasy, scenes, and fetishes.

Kinky sex (or kinky play): Most commonly used to refer to divergent sexual practices in which people derive varying forms of pleasure and consensually play out various forms of desires, fantasies, and scenes.

Lesbian: Typically used to describe a woman who has a pattern of affectional/romantic, emotional, physical, and/or sexual attractions to those of the same gender but may be a term used by nonbinary people.

LGBTGEQIAP+: Lesbian, Gay, Bisexual, [Trans*, Transgender; & Two-Spirit], Gender-Expansive, Queer & Questioning, Intersex, [Agender, Asexual & Aromantic], [Pansexual, Pan/Polygender, & Poly Relationship Systems]. We use the current initialism promoted by the Society for Sexual, Affectional, Intersex, and Gender

Expansive Identities (SAIGE). Similar to BIPOC, limitations are the conflation sexual/affectional orientation and gender identity, diminishes experiences of sexual/affectional, intersex, or gender expansive individuals whose identities are not captured in the acronym, and does not distinguish how LGBTGEQIAP+ peoples' experiences very based on historical influences, intersectionality, and their positionality in the dominant culture.

Libido: Sexual drive or a person's desire for sexual activity. Libido can vary widely from one person to the next, depending on their preferences, life circumstances, and overall health.

Medical trauma: Psychological trauma that can result from negative interactions with the healthcare system, difficult medical procedures or upsetting treatment experiences, and/or diagnoses of serious illness. Medical trauma is more likely to occur with marginalized populations who have historically been erased, minimized, and stigmatized in medical and mental health care.

Noncoercion: One of the six principles of healthy sexual behavior, in which people should have the full ability to choose for themselves how, when, and whether to engage in sexual activities and recognize that consent can change from moment to moment, encounter to encounter.

Normophilic: Behavior that involves fondling or genital stimulation between physically mature, developmentally typical, and consenting human partners (American Psychiatric Association [APA], 2023).

Older adults: Term used to refer to individuals who are 65 years of age and older. Using this term is an intentional act of affirmation and purposeful destigmatization of older adults' presence in society. Terms such as "seniors," "elderly," and "the aged" can be othering (i.e., there is no equivalent term for elderly in younger populations) and invoke negative connotations about older adults (e.g., image of an elderly person as frail and in poor health). Although the terms older adults and older persons are endorsed by the American Geriatric Society (Trucil et al., 2020), terms such as "elders" may be preferred within some cultures, such as in Native American and Pacific Islander communities.

Pan/polygender: A non-binary gender identity referring to people who experience all gender identities either simultaneously or over time.

Pansexual: A person who has the capacity to form enduring physical, romantic, and/ or *emotional* attractions to any person, regardless of gender identity. Also referred to as gender-blind attraction (i.e., attracted to the person).

Paraphilias: Defined as "any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners" (APA, 2023, p. 779). Paraphilias such as sadism, masochism, cross-dressing, and fetishes can be healthy expressions of sexual divergence that would not warrant a diagnosis or treatment.

Paraphilic disorders in the *DSM-5-TR*: To diagnose an individual with a paraphilic disorder, the person must either have acted on their paraphilic interests with a non-consenting person or being, or the paraphilic interests and urges must cause the person distress or impairment in functioning (APA, 2023). Counselors need to critically evaluate when sexually divergent behavior is healthy and ethical to separate sexual divergence from the paraphilic disorders in the *DSM-5-TR.*

Pleasure: A feeling or an experience that feels good, satisfying, or enjoyable.

Polyamorous relationship systems: Sometimes used as an umbrella term for all forms of ethical, consensual, and loving non-monogamy, polyamorous relationship systems denote being open to and/or involved in multiple romantic and/or sexual relationships at the same time, with full knowledge and consent of all involved parties. Some polyamorous people consider "polyam" to be a relationship orientation.

Polyamory: Also known as "polyam," a relationship practice and/or identity that translates as having more than one love. Polyamory is a type of ethical non-monogamy where people within relationships fully consent to include additional partners.

Purity culture: Encompasses the way sociocultural norms and popular media reinforce sexual purity and modesty as a measure of a person's worth. Purity culture places a strong emphasis on traditional gender roles and norms and a strict rule on abstinence from intercourse prior to marriage.

Queer: An umbrella term used to describe gender identities, affectional orientations, and sexual orientations that do not conform to societal norms. Historically, the term has been considered pejorative; however, the term has been reclaimed since the 1970s by some LGBTGEQIAP+ people as their preferred self-identifier, as well as an adjective (i.e., queer politics, queer studies). Some people consider queer to be a more inclusive term, although others within LGBTGEQIAP+ communities do not like the term queer (or associated term "genderqueer"). Queer also sometimes refers to a more radical and confrontational type of LGBTGEQIAP+ activism.

Questioning: A term typically used to refer to the process of exploring one's own gender identity, gender expression, affectional orientation, and/or sexual orientation. Some people may also use this term to name their gender, sexual, and/or affectional identity within LGBTGEQIAP+ communities.

Rape: A form of sexual violence involving non-consensual sexual intercourse or other forms of sexual penetration carried out against a person without their consent. It is often characterized by the use of force, coercion, and/or manipulation, and the legal definition of rape can vary by state.

Respect for others' beliefs and differences: One of the six principles of healthy sexual behavior in which people show regard for and do not force or coerce others to change their sexual beliefs, values, and variations.

Responsibility: One of the six principles of healthy sexual behavior in which people should take accountability for sexual choices and behavior, avoid engaging in sexual practices that harm oneself and others, and be honest and not withhold information from their partners that diminishes their consent and autonomy to engage in sexual activities.

Reverse sex negativity: One of the six principles of healthy sexual behavior, in which people engage in behaviors intended to reduce the shame, stigma, and pathologizing of sex and sexuality.

Scenes: An interaction or time period with a start and stop point in which people are engaging in kinky play. Essential parts of fetish scenes are defining limits and boundaries of the people involved and typically includes aftercare.

Sex and/or **sexual practices:** Refers to the broad spectrum of sexual and intimate acts that can be solo or partnered, with various goals or outcomes (e.g., pleasure, companionship, intimacy, self-expression, procreation), and multi-faceted mental and emotional impacts.

Sex games: Games of a sexual nature, often played by partners as a means of foreplay. Sex games may be traditional games adapted to include sexual elements (e.g., strip poker), commercial sex games (e.g., erotic dice sets), role-playing scenarios, or erotic video games.

Sex-positive (sex-affirming): Emphasizes individual and community practice of openness, honesty, non-judgment, respect, freedom, agency, and liberation from negative sexual attitudes. The foundational assumptions of sex positivity are: a) multiple ways of being, including identities, sexual practices, and desires, are inherently healthy; b) sexuality and sexual health are a lifelong process and integral to connection with others; c) sexual health extends beyond sexual functioning, embracing pleasure, personal and relational satisfaction, and fulfillment as important components of human sexuality; d) positive sexuality is inclusive of intersecting identities and aspects of peoples' lives; and e) sexuality exists on a continuum and is socially constructed.

Sex therapy: A form of intensive therapy to treat sex and sexuality-related concerns that may involve the coexistence of other complex mental health concerns, inter/intrapersonal conflicts, or other major life issues.

Sex trafficking: Instances in which commercial sex is induced by force, fraud, or coercion, or in cases where the person induced to perform the sex act is under the age of 18 (U.S. Department of State 2019). Although individuals who engage in sex work are at increased risk for becoming victims of sex trafficking, it is important to note the distinction between sex workers who consent to provide sexual acts and individuals who are trafficked into sex work and thus compelled into engaging in sexual behaviors without consent (Litam, 2019). Sex trafficking is a crime of

exploitation and a form of modern-day slavery (Centers for Disease Control and Prevention, 2022) that violates bodily autonomy and harms the health of individuals who are trafficked.

Sex workers: Adults who exchange money or goods for **consensual** sexual activities or erotic performances, either regularly or occasionally, and is a term constructed to emphasize sex work as *work*. sex worker as a term has limitations, not everyone who exchanges sex for money would call themselves a sex worker (e.g., some may prefer prostitute or exotic dancer), and the variations of commercial sex work are numerous, with some entering sex work due to limited circumstances for survival, often stemming from other forms of marginalization, and others actively choosing sex work out of pleasure, enjoyment, or empowerment (Sheeger, 2022).

Sexism: Beliefs and/or systemic practices that devalue and discriminate against people on the basis of sex or gender. Sexism often reflects a hatred, dislike, or mistrust of women or people of nonbinary gender identities, based in the belief that men are the superior sex or gender.

Sexual abuse: Any interaction that inflicts unwanted or harmful sexual contact upon a person or being using coercion, compulsion, or force.

Sexual assault: Sexual contact or behavior that occurs without explicit consent of the victim.

Sexual divergence: Sexual divergence is defined by non-typical, non-normophilic, and non-reproductive focused sexual interests, desires, and attraction toward a person(s) or thing(s), or practice(s), that might be considered socially taboo or problematic. Sexual divergence can include sexual paraphilias such as BDSM, kink, fetish, cross-dressing, exhibitionism, voyeurism, and frotteurism.

Sexual dysfunctions in the DSM-5-TR: A group of disorders that are typically characterized by clinically significant distress associated with a person's ability to experience sexual pleasure or respond sexually. The Sexual Dysfunctions section in the DSM-5-TR includes the diagnoses of delayed ejaculation, erectile disorder, female orgasmic disorder, female sexual interest/arousal disorder, and premature (early) ejaculation, in addition to substance-induced, other specified, and unspecified sexual dysfunction.

Sexual exploitation: When a person profits from the use of another person's body in a sexual manner, often through the abuse of a position of vulnerability, differential power, and/or trust.

Sexual expression: The ways in which individuals and partnerships express their sexuality, desires, and sexual identities, encompassing behaviors, attitudes, and practices, including dress, communication, and consensual activities.

Sexual functioning: The predominant framework for conceptualizing sexual functioning in Westernized society since the 1960s has been Masters and Johnson's (1966) sexual response cycle, which has influenced the definitions and associated symptoms of the Sexual Dysfunctions in the DSM-5-TR (APA, 2022). This commonly accepted understanding of sexual functioning is limited in its responsiveness to diverse sexual experiences, specifically for historically and currently oppressed communities, identities, and subcultures. Holistic and depathologizing conceptualizations of sexual functioning emphasize how the interactions between physiological, mental, emotional, spiritual, intrapersonal, and interpersonal responses impact sexual desire, arousal, lubrication, pleasure, orgasm, satisfaction, and intimacy.

Sexual harassment: Any unwanted sexual behavior or conduct of a sexual nature that makes the recipient feel upset, scared, offended, or humiliated. This could include verbal, physical, and non-verbal behaviors (sexual comments, jokes, gestures).

Sexual identity: a person's innermost sense of themselves as a sexual being, which influences how individuals self-identify within social groups.

Sexual protective behaviors: Behaviors that decrease the risk of negative outcomes from sexual encounters, including but not limited to barrier protection (e.g., condoms, diaphragms, contraceptive sponges, dental dams) during vaginal, oral, or anal sex; regular HIV and STI testing; use of contraception (e.g., hormonal contraception or intrauterine devices); only engaging in sexual activities when not under the influence of drugs or alcohol; having a reduced number of sexual partners; and open and honest communication with partners.

Sexual response cycle: A model of physiological sexual response developed by William Masters and Virginia Johnson in the 1960s. The four-stage model describes physiological responses occurring over four stages: excitement, plateau, orgasm, and resolution. The Masters and Johnson model has been critiqued for describing sexual response solely in terms of physiology, when sexual response is also heavily influenced by emotional states. Alternative conceptualizations of the sexual response cycle include the incentive motivation model (Ågmo & Laan, 2022) or the intimacy-based female sexual response cycle (Basson, 2001).

Sexual risk behaviors: Behaviors such as not using barrier protection or contraception, not engaging in HIV or STI testing, having sex while using drugs or alcohol, having anal sex,* having multiple sexual partners,* paying for sexual services,* and not openly and honestly communicating with your partners about your sexual history and/or expectations for sexual activity. Sexual risk behaviors increase the risk of negative outcomes from sexual encounters, such as HIV infection, the contraction and transmission of STIs, or unintended pregnancy.
Note:* Though having anal sex, having multiple sexual partners, and paying for sexual services are behaviors associated with an increased risk for negative outcomes of sexual encounters, adults can safely and consensually engage in these activities by using **sexual protective behaviors.

Sexual roleplay: Roleplay that has an erotic or sexual element involving consenting partners acting out roles or an imaginary scenario to bring to life sexual fantasies. Roleplays may be a means of foreplay, can enhance sexual arousal and desire, and may be a way for some people to overcome sexual inhibitions.

Sexual subcultures: People or communities who engage in sexually divergent interests, desires, attractions, or behaviors towards persons, objects, or practices that deviate from normophilic sexual activities and diverge from heteronormative and monogamous forms of intimacy. Sexual benefits, heightened intimacy, and sexual pleasure are often the focus of sexual interests and activities within sexual subcultures, as compared to the dominant script that the purpose of sexual activity is for procreation. Some individuals may view participation in sexual subcultures as an activity, behavior, or expression, whereas for others, involvement in sexual subcultures becomes a key aspect of their sexual identity (Litam & Speciale, 2019).

Sexual violence: An umbrella, non-legal term used to describe when a person inflicts unwanted or harmful sexual actions onto another person or being through coercion, force, or compulsion. Sexual violence encompasses sexual abuse, sexual assault, sexual harassment, rape, indecent exposure, and sexual exploitation.

Sexual orientation: Pattern of people's sexual attraction based on gender or pattern of non-sexual attraction. Sexual orientation can be fluid, and people use a variety of labels to describe their sexual orientation. Sexual orientation may overlap with affectional orientation and may also involve emotional and romantic attraction to other people. Although sexual orientation can overlap with affectional orientation, they are not always the same; hence, people can have a sexual orientation distinct from their affectional and romantic orientation.

Sexuality: 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, behaviors, practices, roles, and relationships. While sexuality can include all 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

Sexuality counseling: A professional relationship that empowers diverse individuals, families, and groups to (a) increase comfort and awareness of sexuality and sexual experiences; (b) validate sexuality as a core aspect of the human experience that is actively included throughout the counseling process based on the needs of clients; (c) provide empirically-based education, guidance, and resources regarding sexual health concerns; (d) support clients as they navigate various influences on their sexuality in their goal toward overall wellness; (e) empower clients to express their sexuality with respect to their individual and other's sexual rights; and (f) promote sexual wellness. (ACSSW, 2019b, What is Sexuality Counseling? section).

Sexually transmitted infections (STIs): An infection that occurs when viruses, bacteria, or other microorganisms are passed person to person through blood, semen, vaginal fluids, or other body fluids. STIs can be spread during oral, anal, or genital sexual activities with an infected partner, from an infected mother to a child during pregnancy, and through breastfeeding, sharing needles, and blood transfusions.

Transgender: An umbrella term for people whose gender identity and/or expression is different from cultural expectations based on the sex they were assigned at birth.

Trauma-informed care: Trauma-informed care recognizes the prevalence of trauma and how trauma impacts people at both individual and systemic levels. As with sexuality, trauma must be viewed through a sociocultural and ecological lens. Counselors and organizational leaders are encouraged to respond to trauma at an environmental level, establishing policies, practices, and supports that promote recovery and actively resist re-traumatization. SAMHSA (2014) established six guiding principles of trauma-informed care are a) safety, b) trustworthiness and transparency, c) peer support, d) collaboration and mutuality, e) empowerment and choice, and f) cultural, historical, and gender issues.

Two-Spirit: A term formally adopted in 1990 at the 3rd Annual Native American Gay and Lesbian Gathering, although Two-Spirit is a concept that Indigenous Native American communities have identified with for centuries. Two-Spirit is an umbrella term that bridges Indigenous and western understandings of gender and sexuality, often used to refer to an embodiment of masculinity and femininity. In most tribes, Two-Spirit people are considered to occupy a distinct and alternative gender status. Two-Spirit people are often considered sacred or divine and serve integral and important roles in their communities, such as leaders and healers.

Virtual sexual subcultures: People or communities who engage in sexually divergent norms, values, or beliefs in online spaces. Virtual subcultures can occur through real life interactions as well as those who never interact in real life (e.g., using artificial intelligence or virtual reality). Participation in virtual sexual subcultures can follow the principles of healthy sexual behavior and be consensual and playful spaces that help people connect. Given the anonymity, difficulty in regulation, and expansiveness of online spaces, however, virtual sexual subcultures may also proliferate harm to others (e.g., sharing of nonconsensual sexual images or images of child sexual abuse) and enable individuals to engage in radical and dangerous sexual activities.

White patriarchy: The systemic power and privilege held by white men in society, which oppresses and marginalizes any non-white, non-cisgender male identities.