Preface

Why This Book?

We wrote this book to support counselors and helping professionals in developing a foundational knowledge base in sexuality counseling. The World Health Organization (2024) defines sexual health as a basic human right, and sexuality is a normal, healthy, and integral part of the human experience. Yet, many of us, including ourselves, have encountered messages that stigmatize or misrepresent sex and sexuality. In counseling, clients may present with feelings of guilt or shame linked with their sexuality, labeling their natural desires for who they were attracted to, the type of sex they wanted to have, or their sexual fantasies as "bad" or "abnormal." Clients may have difficulty talking to their parents, friends, or intimate partners about sex. These varying messages, feelings, and comfort levels extend to us as counselors. Every counselor has had a unique set of life experiences, so it's likely that every reader has different aspects of sexuality that are more or less difficult to discuss with clients. Avoiding conversations about sexuality in counseling creates more sexual anxiety and shame and continues to marginalize an essential aspect of humans' lives and relationships. By the end of this text, we hope readers walk away from this text with an enhanced understanding of sexuality and a commitment to ongoing learning. We also hope our readers gain the tools and confidence to open conversations about sex, not only with clients but also in their personal lives and larger communities.

The second edition of *Sexuality Counseling: Theory, Research, and Practice* is grounded in our integrative, multilevel conceptual framework, the *Contextualized Sexuality Model*, which addresses the various levels that formulate positive sexuality. Specifically, these sexuality levels include cultural and contextual, developmental, gender identity, affectional and sexual orientation, diverse sexual expressions and communities, intimate relationships, recovery from sexual trauma, mental health, and physiological health. Through addressing all these important concepts and their relevance to sexuality counseling, the book provides a unique perspective for counseling students to see how sexuality is embedded in many other mental health issues and human behaviors. Our text is rooted in sound theory and recent interdisciplinary research, emphasizing practical and evidence-based strategies for sexuality counseling practice. Finally, *Sexuality Counseling:, Theory, Research, and Practice* is a book that was designed to assist both counseling trainees and mental health professionals in developing their professional identity and practice in sexuality counseling.

Throughout this text, we provide: (a) reflection questions to help readers develop self-awareness of their values, beliefs, and attitudes towards sexuality, (b) critical self-reflection exercises to deepen understanding of how their perspectives influence professional practice, and (c) case illustrations for readers to practice applying content to real-world clinical scenarios. We

structure the exercises throughout each chapter so they can be done on one's own or used by instructors in small-group discussions or experiential exercises during class. We close each chapter with a list of additional resources, inclusive of sexual health organizations, client-facing supports, and recommended educational materials.

Approach

As discussed throughout this text, we integrate developmental, strengths-based, interdisciplinary, critical, and constructivist perspectives into our approach to sexuality counseling, centering the *Contextualized Sexuality Model* as a positive, holistic, and pleasure-affirming framework. First, we believe sexuality has to be understood through a developmental lens, as a lifelong, evolving experience shaped by our individual and collective histories, cultural backgrounds, and current circumstances. The counseling philosophies of holism, wellness, and strengths-based approaches are among our strongest contributions that we counselors add to the mental health and sexuality counseling fields, promoting the developmental conceptualization of sexuality from a positive, pleasure-informed perspective rather than dysfunction- or deficit-driven frameworks that have historically dominated the field. Further, we recognize that clients' sexual wellness cannot be viewed in a vacuum and needs to be addressed comprehensively through working with other professionals such as medical providers, sexual health educators, public health specialists, and K–12 teachers and administrators. We also incorporate critical approaches to center how sociocultural and institutional contexts can enhance or diminish sexual wellness, and highlight how intersecting experiences of oppression impact sexual health as a human right. Finally, a constructivist approach recognizes how we create meaning through social relationships and discourse, acknowledging the complex, fluid, and subjective nature of sexuality and sexual relationships. There are multiple ways we integrate our approaches to sexuality counseling throughout this text. The *Contextualized Sexuality Model* offers a positive sexuality framework that promotes counselors' use of contextualized, systemic, and pleasure-affirming interventions. We integrate a developmental approach by providing information on how sexuality may evolve across the lifespan, with a focus on the unique needs of clients based on context and age. Moreover, we use research from a variety of disciplines, including counseling, psychology, social work, nursing and medicine, public health, and sociology. We identify how interprofessional collaboration may benefit clients throughout the text and provide links to interdisciplinary organizations and resources at the end of each chapter. In terms of critical approaches, we frequently provide brief histories of topics within the sociocultural context and how the mental health and medical fields have evolved in approaching various areas of sexuality over time. We also provide advocacy strategies for counselors to support efforts toward removing barriers to clients' well-being and promoting systemic change. As part of a critical and constructivist approach, we continually ask readers to engage in reflective exercises on how they interpret and understand human sexuality and to critically examine their own comfort and discomfort with sexuality-related topics.

Organization of the Book

This book is organized into three main sections: (a) background on sexuality counseling, (b) identities, relationships, and communities, and (c) sexuality counseling in context. The first four chapters provide foundational background on the practice of sexuality counseling, including ethics and professional competence, general assessment and treatment interventions, and cultural, contextual, and developmental considerations. We also present the *Contextualized Sexuality Model* as an organizational framework for understanding the diverse influences on sexuality-related issues that clients bring to counseling, as well as the remaining book chapters. In the second section, Chapters 5 through 8 explore aspects of identity and connection that impact sexuality, including gender identity, affectional and sexual orientation, diverse sexual expressions and communities, and intimate relationships. In the final section, the remaining chapters review specific topics and presenting issues that are commonly seen in sexuality counseling, such as healing from sexual trauma, the intersections between sexuality and mental health, and physiological influences on sexuality. Chapter 12 closes the text by revisiting the *Contextualized Sexuality Model* through a sex positive lens, with a focus on interventions that enhance sexual wellness and pleasure for individuals, relationships, and communities.

New to This Edition

We used feedback from both students and instructors who used the 1st edition of our text to inform the exciting updates to this new edition of *Sexuality Counseling: Theory, Research, and Practice.* One of the key changes in the 2nd edition is the new organization, with the first four chapters laying the foundation for general sexuality counseling practice, the next four chapters reviewing identity and relationship development, and the concluding four chapters taking a more in-depth look at specific topics related to sexuality counseling.

In the 2nd edition, we start each chapter with questions to promote readers' self-reflection. Additionally, we integrate assessment and treatment strategies related to each level of the *Contextualized Sexuality Model* within each chapter, providing sample assessment questions, suggested instruments, and targeted theoretical interventions for each area. The 2nd edition offers new case illustrations that represent the diversity of sexuality across the lifespan and prompts for readers to reflect on their personal reactions to each case. Readers will find new and engaging exercises throughout the text, such as:

- responding to sexuality and values prompts in Chapter 1
- identifying LGBQA+ history, role models, and media representations in Chapter 6
- practicing the development of relationship agreements in Chapter 7
- learning about sexual and reproductive anatomy in Chapter 11
- developing positive messaging about sexuality in Chapter 12

As with the 1st edition, we drew heavily on interdisciplinary research published within the last ten years to guide our content and conclude each chapter with an updated list of Additional Resources.

In Chapter 1, we expand upon the *Contextualized Sexuality Model,* distinguishing between gender identity and affectional/sexual orientation, and adding the influences of diverse sexual expressions and communities and sexual trauma and healing. We briefly introduce each area of the *Contextualized Sexuality Model* and provide a deeper dive into the historical, societal, and cultural context that informs our current conceptualizations of sexuality. Lastly, we elaborate on the role of cultural humility and critical introspection in developing effectiveness in sexuality counseling.

Chapter 2 integrates the assessment and theoretical approaches chapters from the 1st edition, providing a generalized overview of assessment and intervention strategies to address sexuality-related concerns in counseling. Updated content includes: (a) a brief review of how critical theories inform sexuality counseling with diverse populations and advocacy efforts to increase sexual health for all people; (b) an overview of how trauma-informed treatments intersect with sexuality counseling, and (c) an updated examination of cognitive behavioral and systemic interventions based on recent research.

In Chapter 3, we add a general introduction about cultural competence as it relates to sexuality counseling, grounded in the U.S. Substance Abuse and Mental Health Services Administration's *Treatment Improvement Protocol (TIP) 59: Improving Cultural Competence*. We also dive further into historical and political influences on sexuality and culture.

Chapter 4 expands upon key aspects of sexual development, namely gender identity and affectional/sexual orientation development across the lifespan. We also provide more detailed information about sexual development in later adulthood.

Chapters 5 and 6 split the gender identity and affectional/sexual orientation chapter of the 1st edition into two chapters, providing more expansive content on the influence of historical and sociocultural factors related to these two key areas of the *Contextualized Sexuality Model.* In Chapter 5, we dive further into gender diversity, paths of transitioning, evidence-based gender-affirming counseling practices, and advocacy strategies to create gender-inclusive spaces. Similarly, in Chapter 6, we expand on affectional and sexual orientation diversity, adding more content on bi+ and asexual/aromantic ways of being, along with current and research-supported strategies for affirming counseling.

In our first new chapter, Chapter 7, we cover key information and counseling practices for people with diverse sexual expressions or who participate in diverse sexual communities. Chapter 7 opens with an overview of consensual non-monogamy, as well as counseling considerations for clients in diverse relationship structures. We define kink, reviewing specific aspects of kink culture, such as active collaboration, enthusiastic consent, and aftercare. We dive further into specific kink practices, such as BDSM, fetishes, solo play, and online sexual subcultures, again reviewing counseling strategies that support clients with healthy and ethical erotic exploration.

Within Chapter 8, we elaborate on how interpersonal attractions, love, attachment, and interaction patterns influence sexual satisfaction and relational well-being. We expand upon two of the predominant and empirically supported treatment approaches for couples and relationship

counseling, Emotionally Focused Couples Therapy and the Gottman Method, detailing specific interventions for synthesizing relational and sexuality counseling.

Our second new chapter, Chapter 9, focuses on the topic of recovery from sexual trauma. We start this chapter with an overview of the different types of sexual trauma. We review the prevalence and impacts of sexual trauma. We conclude this chapter with assessment and counseling strategies grounded in a trauma-informed approach, understanding the complex and multilayered nature of healing from sexual trauma.

Chapter 10 provides new content on the impact of trauma and stressor-related disorders on sexual health and updated information on the sexual dysfunctions to coincide with the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (DSM-5-TR). We also incorporate contemporary research and evolving perspectives on compulsive sexual behavior, distinguishing compulsive sexual behavior from sex offending, concluding with counseling strategies for both types of presenting concerns.

We expand upon the intersections between physiology and sexual health in Chapter 11, starting with a basic overview of sexual and reproductive anatomy. We offer updated counseling strategies to promote healthy sexual practices and add specific sections on how weight fluctuations and age-related changes can impact sexual health.

In our concluding chapter, Chapter 12, we revisit the definition of positive sexuality, with an enhanced focus on sexual pleasure in addition to sexual health and wellness. We return to each area of the *Contextualized Sexuality Model,* with a review of counseling strategies that promote positive sexuality across the lifespan. We provide a new section on the sociocultural health benefits of positive sexuality, aligning with our framework of understanding sexuality through individual, relational, and sociocultural perspectives throughout the book.

Pedagogy

We rely heavily on andragogy, experiential learning, and transformative pedagogical approaches when teaching sexuality counseling content. For andragogy, or adult learning, we suggest instructors use tools that promote peer collaboration (such as the group-focused exercises we offer in Chapter 2) and interactive activities that encourage peer feedback. Learner-to-learner interactions provide alternative ways for students to receive feedback and can promote critical self-reflection through interpersonal exchanges. Flexible assignment options allow learners to choose specific topics or assignment types (e.g., write a blog post, prepare a public policy speech, record a brief podcast interview) that fit their personal strengths and professional interests. Inviting guest speakers from interdisciplinary backgrounds can increase learner engagement and understanding of the interprofessional collaboration that is necessary for comprehensive sexuality counseling.

Experiential learning is also critical to teaching sexuality counseling, encouraging learners to increase their comfort with sexuality-related topics and apply content to practice. Many of the exercises throughout this text have an experiential component, such as having a conversation with a parent concerned about their young child's sexual behavior in Chapter 4, practicing using

gender-neutral language in Chapter 5, or developing a policy on secret-keeping in relationship counseling in Chapter 8. As self-awareness and comfort are foundational to effective sexuality counseling, role plays and collaborative activities that allow learners to try out new language and skills are essential for professional development in this area. Assignments also can have experiential components, such as responding to first-person narratives as if those persons were clients or engaging in a sexuality encounter of the learner's choice (e.g., attending an erotic art exhibit, interviewing someone who participates in a fetish community). Experiential learning activities should always include a reflective component for learners to describe and analyze their experience and apply what they learned to new contexts and sexuality counseling practice.

Lastly, using transformative or critical pedagogy is crucial when teaching sexuality counseling. The goal of this pedagogical approach is to provide learners with opportunities to critically examine their assumptions, reflect on the impact of the sociocultural context on both themselves and their clients, and identify counseling and advocacy strategies that promote systemic changes that enhance sexual wellness for all people. Exercises throughout our text, such as the contextual influences on sexuality in Chapter 3 and the exploration of sociocultural norms about intimate relationships in Chapter 7, prompt readers to consider what messages and expectations about sexuality they have encountered throughout their lives and from what contexts. Additionally, multiple activities encourage readers to discover relevant policies, legislation, and resources at the local and state levels, such as identifying their local and state resources for transgender and gender diverse people in Chapter 5 and mandatory sexual abuse reporting requirements for their jurisdictions in Chapter 9.

Finally, the book offers opportunities for readers to critically analyze the information they gain throughout this textbook or the course. For example, we encourage instructors to use journaling prompts or class discussions that review questions such as:

- What did you learn from the course material that has informed, enhanced, and/or challenged your perspectives on this topic?
- How could the material be developed or implemented in a more culturally responsive way?
  - What or whose perspectives were missing?
  - Whose worldviews or perspectives dominated this topic?
  - How was the status quo questioned or upheld?
- What is one sociocultural, policy, or systemic change related to this topic that could promote people's sexual health or pleasure related to this topic?

Interestingly, learner responses from similar questions in previous sexuality counseling courses helped inform updates to this new edition! We encourage instructors to use learner feedback, in addition to relevant research and pedagogical approaches, to continually adapt their sexuality counseling courses. As the field of sexuality counseling and our related sociocultural landscape is constantly changing, an evolving approach to teaching this content is necessary to keep it interesting and relevant to learners.

Chapter 1

Addressing Sexuality in Professional Counseling

Learning Questions

- **1.1** What are the major components of the Contextualized Sexuality Model?
- **1.2** What are the key distinctions between sexuality counseling and sex therapy?
- **1.3** What are foundational areas of professional competence in sexuality counseling?
- **1.4** What are ethical considerations for conducting sexuality counseling?

Introduction

As we begin this chapter, we encourage you to consider the following questions: *What is sexuality? What is your understanding of sexuality? To what extent does sexuality define people's lives and intimate relationships?* We would wager a guess that if we asked these questions to 10 people, we would hear 10 very different responses. We've grown accustomed to the interesting looks and responses we get when we tell people we address the topic of sexuality in our teaching, research, and clinical practice, and the responses were similar when we shared the news with our friends and family that we were writing this book. We need to look no further than these responses to know that sexuality is a topic to which people ascribe a lot of meaning, which gives rise to a range of emotional and attitudinal responses, both positive and negative.

We can see the confusion about sexuality at a cultural level as well. On the one hand, sex is virtually everywhere, such as in popular music, advertising, movies, and television. On the other hand, many people are very uncomfortable with even the idea of discussing sex in their most personal relationships, including with their romantic partners and their children. According to the Sexuality Information and Educational Council of the United States (SIECUS, 2022), comprehensive sex education is very limited in school settings in many geographic areas. From a family systems perspective, the issue of sex in society is a classic "double bind," in that there

are conflicting social messages of "Have a lot of sex" and "Don't have sex or at least not unless you are in a committed or marriage relationship," along with the third message of "Please, *please* don't talk about it!"

Despite their professional training, counselors are not immune to the discomfort surrounding sexuality (Bungener et al., 2022; Emelianchick-Key et al., 2021; Wilson, 2019). Training in sexuality counseling is not required for many mental health professionals (Cardona et al., 2022), so unfortunately, many counselors enter their professional careers without having any formal education on how to address sexuality-related issues with their clients. Counselors are, of course, human first and as such, they are products of their social and cultural environments, and therefore often experience a good deal of anxiety or discomfort discussing sexuality (Bungener et al., 2022; Juergens et al., 2009; Nasserzadeh, 2009; Wilson, 2019). Even counselors who feel generally comfortable discussing the topic often have certain sexuality-related topics that are more anxiety-provoking than others. And yet, how can counselors expect their clients to be comfortable discussing their sexuality-related concerns when they themselves are not comfortable with these topics?

Clients often seek counseling for concerns related to their sexuality, whether as their primary concern or as a secondary concern to more pressing issues (Miller & Byers, 2010; Southern & Cade, 2011). Further, most patients in the United States felt that healthcare services should encompass sexual health, and about half believed that providers should bring up the topic of sexuality (Zhang et al., 2020). However, many counselors likely do not view sexuality concerns as being within the scope of their professional practice. In many cases, clients' sexuality-related concerns are never addressed or are addressed inadequately. The reasons for this may include that their counselors fail to ask about their sexuality-related concerns, that clients do raise the issues but counselors move on prematurely to discussing other concerns, and/or that clients and counselors fumble through discussing these issues at a surface level but fail to address them with enough depth to produce meaningful change.

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

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

Defining Sexuality

One of the most comprehensive and widely cited definitions of sexuality is the following one put forward by the World Health Organization (WHO; World Health Organization, 2024):

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

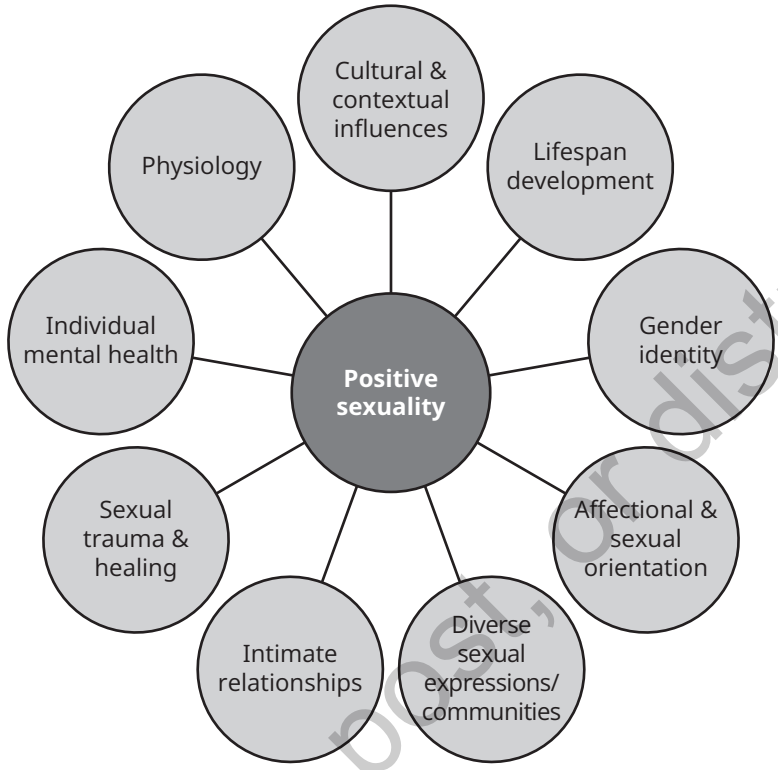
WHO's definition shows that sexuality is far broader than many people initially assume, encompassing both individual and contextual aspects. Further, the term *sexuality* refers to more than the physical act of sex or intercourse, and includes our identities, relationships, preferences, and behaviors. The WHO (2024) definition of sexuality also emphasizes that sexuality is a very individual aspect of people's lives, shaped by individual level factors such as physiology, and mental health, community level factors such as family and social relationships or religion/spirituality, and societal factors such as historic trends and legislation. Given all of the varying influences upon sexuality, each and every person expresses their sexuality in a unique and personalized manner.

A Contextual Model for Understanding Sexuality

Scholars advocate for a comprehensive, integrative, multidisciplinary approach to understanding human sexuality (e.g., Levine, 2009; Zeglin et al., 2019; Zielinski, 2013). As such, this book is grounded in the comprehensive, contextual conceptualization of human sexuality that is presented in Figure 1.1. We refer throughout this book to this framework, which we call the *Contextualized Sexuality Model*, as an organizational framework for understanding the diverse influences on the sexuality-related issues that clients bring to counseling.

The paradigm of *positive sexuality* (also termed sex positivity) is at the center of the Contextualized Sexuality Model. The notion of positive sexuality normalizes sexuality as part of the human experience, acknowledging how sexuality can provide an important avenue for personal and relational growth. Historically, much of the emphasis on sexuality within the mental health professions has focused on the treatment of sexual dysfunctions and other problematic areas of clients' expression of their sexuality (Burnes et al., 2017; Cruz et al., 2017; Zeglin et al., 2019). Clients need not be experiencing sexual difficulties to benefit from addressing sex and sexuality within counseling, and sexual wellness and health are not merely the absence of sexual problems and dysfunctions. Rather, clients' expressions and experiences of their sexuality

Figure 1.1 ▪ *The Contextualized Sexuality Model*



can provide insights and opportunities for enhancing their personal development and achieving greater connectedness and fulfillment within their lives.

Central to positive sexuality is the concept of sexual health. WHO (2024) defines sexual health as:

> a state of physical, emotional, mental, and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected, and fulfilled (para 3).

The Association of Counseling Sexology & Sexual Wellness (2019b, What Is Sexual Wellness? Section) expands on WHO's definition of sexual health, recognizing sexual wellness as holistic and subjective, encompassing diverse sexual expressions, practices, and influences. Hence, sexual health is directly related to overall well-being, encompassing a variety of aspects beyond sexual functioning, including pleasure, satisfaction, freedom, enjoyment, and safety.

Beyond sexual health, positive sexuality contextualizes sexuality as a dynamic and pluralistic construct, acknowledging the fluidity and variability of sexuality over our lifespans (Burnes et al., 2017; Cruz et al., 2017; Mosher, 2017). Positive sexuality not only affirms, but celebrates diverse bodies, identities, sexual expressions, and practices (Mosher, 2017). Further, positive sexuality as a paradigm values all types of relational and sexual intimacy and connectedness, as long as consent, integrity, and autonomy are respected (see discussion of the principles of ethical sexual behavior later in this chapter) (Burnes et al., 2017). As individual sexuality cannot be separated from sociocultural influences, positive sexuality also recognizes the impact of institutional and systemic oppression, and how these systems of power marginalize sexualities that do not align with the dominant norms and contribute to social disparities that impact sexual health for diverse populations (Burnes et al., 2017; Cruz et al., 2017; Mosher, 2017). A positive sexuality approach calls for counselors to engage in advocacy to create more equitable systems that promote the sexual health of *all* individuals and communities. As such, we provide recommendations for clinical interventions and systemic advocacy related to sexuality counseling throughout this text.

The Contextualized Model holds that positive sexuality is a core component of human life, and it is embedded within numerous contextual influences. As shown in Figure 1.1, the contextual influences on human sexuality that will be discussed throughout the rest of the book include cultural and contextual influences, developmental influences, gender identity, affectional and sexual orientation, diverse sexual expressions, and communities, intimate relationships, sexual trauma and healing, individual mental health, and physiology. These influences interact to impact a person's development of positive sexuality. These influences are reciprocal, in that each one influences a person's positive sexuality, and likewise, one's views of and experiences with sexuality can impact growth and development in the contextual areas. Positive sexuality is inherently linked to these influences, as each factor impacts the role sexuality can play in people's lives.

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

*All case illustrations in this book are fictional and not based on real individuals.

Case Illustration 1.1 The Case of Elena and Sophia

Elena (age 68, she/her) and Sophia (age 63, she/her) are a mixed-race couple. Elena is multiracial (Taiwanese American and Italian American), and Sophia is White, a first-generation immigrant from Ukraine. They have been in a committed relationship for 20 years and were married seven years ago after the legalization of same-sex marriage in the United States. They report that they share a loving, stable relationship and feel supported and loved by their children, family, and friends. They are seeking counseling because they are both nearing retirement and are concerned about the stress this transition may bring to their relationship. They indicate that one of their major concerns is the impact that this transition will have on their sexual relationship. Both partners state that they view the physical and sexual intimacy they share as an important avenue for growing their relationship and fostering personal growth. However, because Elena's level of sexual desire has grown increasingly greater than Sophia's for the past several years, they are concerned that this will be an area for conflict once they end their careers and have more free time.

Case Illustration 1.2 The Case of Mirabel, Omar, and Ridley

Mirabel (she/her, age 32, Colombian American), Omar (he/him, age 40, Arab American), and Ridley (he/they, age 38, White) have been living together in a committed nonhierarchical polyamorous relationship for two years. Ridley has a 7-year-old child, Sam, from their previous relationship. Although Ridley shared custody and Sam stayed at the house with all three partners, Sam primarily resided with his mom. Sam's mom recently died in a car crash, and Sam has come to live with Ridley, Mirabel, and Omar full time. The partners present to counseling to navigate this changing dynamic in their relationship and revisit their relationship agreement, now that Sam has become a permanent part of their family. Ridley reports getting less time with both Mirabel and Omar. Ridley also has not been physically intimate with either partner in over a month between the demands of their job and caring for Sam. Mirabel and Omar both miss their connection with Ridley and acknowledge they have pulled away somewhat. They are unsure how to support Ridley and share the responsibility of parenting Sam, as previously they acted as more of the "fun aunt and uncle" to Sam.

Case Illustration 1.3 The Case of Joanna and Idris

Joanna (she/her), a 58-year-old Black woman, and Idris (he/him), a 45-year-old Black man, have been married for five years. This is the second marriage for each partner. The partners chose to be child-free, and both enjoy busy and fulfilling jobs. However, Idris is currently being treated for Major Depressive Disorder (MDD), and his treatment includes monthly meetings with a counselor and an antidepressant medication. Idris reports that since he was diagnosed with MDD and began taking medication, he has lost any interest in sex. Joanna reports that she is frustrated and would like to have a sexual relationship but says that she just turns her focus to her work to keep her mind off her frustrations while Idris is being treated.

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

Cultural and Contextual Influences

Tiefer (2009) defined sexuality as:

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

Tiefer's (2009) perspective on sexuality contrasts with many common assumptions that sexuality begins with the physical components and our goal is not to determine which perspective

is the most accurate. However, Tiefer's commentary on the political nature of sexuality provides an important reminder that sexuality always occurs within sociocultural contexts and that sociocultural norms and rules determine how clients experience and express their sexuality. These contextual influences include race, ethnicity, nationality, and culture, but they also extend to historical and familial influences, religion and spirituality, socioeconomic factors, geographic influences, and the influences of the Internet and the media (Althof, 2010; Levine, 2009; Pope et al., 2024a; Zeglin et al., 2018).

Developmental Influences

Human sexuality can be viewed as a lifelong process that grows and evolves as people move through various developmental phases in their lives and relationships. Expectations surrounding people's sexuality often begin even while in the womb, such as through the gender expectations that arise when parents learn their baby's sex and through comments that people often jokingly make about the possibilities for the baby's future (e.g., "Someday your child will marry mine so we can be family!"). Sexuality in childhood often takes the form of curiosity, exploration, and many, many questions. Parents and educators often struggle with how best to talk with children about their emerging sexuality (Willis et al., in press). Further, childhood trauma, including neglect and emotional, psychological, sexual or physical abuse, has lasting impacts that can affect experiences of sex and sexuality over the lifespan (Covington, 2022).

As individuals progress through adolescence and young adulthood, their emerging sense of themselves as sexual beings continues to evolve as they navigate dating, intimate relationships, and realities about the potential consequences of sexual activities (e.g., sexually transmitted infections [STIs] and unplanned pregnancies). Throughout all of adulthood, people grow and change in their sexuality in unique and individualized ways. Although older adults are often stereotyped as being nonsexual (Srinivasan et al., 2019), many adults continue to enjoy a healthy sense of sexuality throughout their entire lives. Overall, then, it is important for sexuality counselors to understand common sexuality-related developmental transitions, challenges, and opportunities that people face and how these impact clients' concerns in counseling (Althof, 2010).

Gender Identity

Sexuality is undoubtedly impacted by how people view and experience their gender identity. Gender refers to society's expectations and norms regarding what it means to be a woman, man, or another gender, while gender identity is rooted in an individual's internal sense of their own gender (Coleman et al., 2022; Singh, 2018). For some people, their gender identity aligns with the gender they were assigned at birth based on their biological sex characteristics, known as being cisgender. For others, however, their gender identity may shift and evolve over time, often as they gain greater self-awareness and reflect on what gender means to them. Gender identities are multifaceted, relational, and dynamic, shaped by social, historical, political, and cultural contexts. Understanding gender as a social construct (Lorber, 2018) is crucial for recognizing the diverse range of gender identities you may encounter in counseling.

As more individuals self-realize as transgender or gender diverse (TGD), inclusive of nonbinary and intersex individuals (Jones, 2024), counselors need to be prepared to understand the unique concerns these clients face and to provide culturally responsive, gender-affirming mental health care. Counselors can support gender diverse individuals in a variety of ways, including managing marginalization stress, enhancing social support networks, and navigating social, legal, or medical transitioning. Systemic advocacy and resource coordination are also critical parts of gender-affirming counseling to remove barriers and increase access to services that support the well-being of gender diverse people.

Affectional and Sexual Orientation

Human attraction is multifaceted, fluid, and complex, involving a person's sense of aesthetic, emotional, erotic, intellectual, platonic, romantic, sexual, and/or spiritual attraction toward another person. Hence, affectional and sexual orientation are key aspects of human sexuality. Affectional (romantic) orientation refers to the way people experience emotional or romantic attractions, which may or may not be connected to sexual or physical attraction. For some people, affectional orientation and sexual orientation are distinct experiences—for instance, a person may be asexual, in that they generally do not experience sexual attraction or desire, and monoromantic, emotionally, mentally, and/or spiritually attracted to people of one gender. Further, like gender identity, affectional and sexual orientations are shaped by social, historical, cultural, and political influences. Recognizing that affectional and sexual orientations are influenced by both biology and our current contexts is crucial for understanding the wide array of affectional and sexual orientations of your clients (Ventriglio et al., 2021).

As approximately 20% of Generation Z identifies as LGBTQ+ (Jones, 2024), all counselors should expect and be prepared for working clients with varying affectional and sexual orientations in counseling. Counselors should be aware of the spectrum and fluidity of these identities, familiarize themselves with dominant terminology and affectional and sexual identity development milestones, and engage in ongoing education about sociocultural changes that impact the lived experiences of LGBTQ+ communities. As with gender diverse individuals, affectionally and sexually diverse people are often navigating a world that marginalizes and negates their identities and attractions, so addressing marginalization stress, enhancing positive identity and social support, and advocating at societal and institutional levels to create more equitable, sustaining, and celebratory systems are critical components of LGBTQ+ affirming counseling (Pope et al., 2024b).

Diverse Sexual Expressions and Communities

Historical and sociocultural understandings of sexual normalcy and deviation, along with medical and psychological frameworks of sexuality, shape how we view diverse sexual expressions and relationships. A modern understanding of sexuality includes sexual pleasure as a key element of sexual health, with principles such as consent, autonomy, and respect guiding ethical sexual behavior (Braeken & Castellanos-Usigli, 2018; WHO, 2024). Individuals may engage in diverse sexual interests, desires, attractions, and behaviors, often with the goals of enhancing intimacy

and sexual pleasure (Yates & Neuer-Colburn, 2019). Diverse sexual expressions and communities include those such as consensual non-monogamy (CNM), kink communities, and virtual sexual subcultures., emphasizing that engaging in one practice doesn't imply participation in others.

As the societal visibility of these communities grows, counselors are encouraged to critically examine their own values regarding intimacy, relationship structures, and diverse sexual practices, reflecting on their beliefs about what is "normal" sexual expression and how these may impact their work with clients. As reviewed later in this chapter, the key principles of ethical sexual behavior such as consent, autonomy, and respect are especially important for individuals and communities with diverse erotic identities, as they often seek out the practices and relationships explored in this chapter to enhance pleasure, engage in self-exploration, and deepen intimacy. Counselors should support clients in adhering to these principles and avoid pathologizing diverse erotic expressions and consensual sexual practices, holding space for clients' self-exploration and the development of intimacy with themselves and with others.

Intimate Relationships

Sexuality is constructed and expressed through interpersonal relationships throughout the lifespan (Pope et al., 2024a; Zeglin et al., 2018). Intimacy refers to a deep sense of connection, trust, and familiarity between people and can manifest in different forms, involving emotional, physical, sexual, erotic, intellectual, and/or spiritual aspects (Zeglin et al., 2018). Intimacy is a crucial component in close relationships, whether familial, platonic, or romantic. Though the majority of adults in the U.S. live with romantic partners, the landscape of romantic and marital relationships has changed significantly in the past few decades. Marital and birth rates are declining internationally (Medaris, 2024; Ortiz-Ospina & Roser, 2020), with a growing number of young and middle-aged adults in the U.S. who are unpartnered or living alone (Fry & Parker, 2021). When we refer to intimate relationships throughout this text, we are primarily referring to romantic relationships; however, we want to emphasize that interpersonal intimacy can take many variations, with more adults finding intimate connections through companionship, platonic relationships, or other social connections. Further, intimate relationships can come in many forms, encompassing friendships, casual dating relationships, domestic or cohabiting partnerships, and marital relationships. Intimate relationships also can involve more than two partners through consensual non-monogamy, such as open relationships or polyamory.

Physical intimacy and sexual activity often occur within the context of intimate relationships, and so the health and dynamics of that relationship contribute to how sexual and relationship partners experience sex and sexuality (Johnson et al., 2018). Even solo sexual activity, such as masturbation, can be a vulnerable experience impacted by our interpersonal relationships that shape how we relate to our bodies, physiological sensations, and emotions (Johnson, 2017). There are many myths about sex in intimate relationships that can contribute to unrealistic expectations and sexual dissatisfaction, such as "Sexual problems mean our relationship is in trouble" or "The best sex is spontaneous." Although there may be some truth to these statements for some partners, counselors must set aside the assumptions that they hold about the role of sex in intimate relationships, as clients will vary widely in their sexual attitudes, behaviors, and

practices within their relationships. For some partners, sex is a primary vehicle for connection, while others do not desire or value sexual intimacy and may seek connection in various other ways. Further, some people may have difficulty with or be unable to engage in sexual activities, due to disabilities or physical health constraints, but can engage in physical intimacy in other ways in their relationships. Hence, it is important for counselors to recognize the validity of the various manifestations of intimacy and situate sexuality in a relational context when working with clients.

Sexual Trauma and Healing

Trauma can profoundly affect a person's sexuality and sexual experiences. Traumatic events, such as sexual abuse, assault, violence, or exploitation, influence physiological sensations, emotional reactivity, feelings of safety, sense of self, body image, and the ability to connect with others, each of which plays a role in shaping one's sexuality (Covington, 2022; Zoldbrod, 2015). Sadly, rates of childhood sexual abuse remain high, as approximately 21% of youth will experience sexual abuse in childhood (Finkelhor et al., 2024). Oppression also results in people from marginalized backgrounds being more likely to experience sexual violence. Children and young adults, women, TGD individuals, indigenous persons, and people from lower socioeconomic statuses are at increased risk for sexual violence and exploitation in the U.S. (Centers for Disease Control [CDC], 2024; Rape, Abuse, and Incest National Network [RAINN], n.d.).

Important components of counseling clients who have experienced sexual violence are reestablishing trust and safety, enhancing self-regulation, processing and integration of traumatic memories, and reconnecting with self and others. Trauma-focused treatments generally follow a phasic structure of (a) establishing the therapeutic relationship, (b) providing psychoeducation and teaching self-regulation strategies, (c) trauma remembering and narrative processing, and (d) resiliency building toward post-traumatic growth (Gentry et al., 2017). Cognitive behavioral approaches have demonstrated effectiveness in addressing trauma resulting from sexual violence, including childhood sexual abuse and sexual assault, with components focused on narrative or imaginal exposure, cognitive restructuring, and behavioral activation (McTavish et al., 2021; Miles et al., 2024). Additionally, mind-body and group-based therapeutic approaches can help survivors reclaim their bodily autonomy and engender healing connections with others (Nixon, 2024).

Individual Mental Health

A person's overall mental health is closely intertwined with their sexuality (Levine, 2009). Sexuality is one avenue through which people express their beliefs, values, feelings about themselves, and body image (Juergens et al., 2009). Further, the brain plays a critical role in shaping and regulating sexual arousal, attraction, and behavior. Therefore, one's sexuality can impact one's mental health, and one's mental health can impact one's sexuality. For example, a client presenting with depressive symptoms may report a loss of interest in sexual activities, and this loss of interest in sex may also bring about stress about one's sexuality and relationships. Indeed, researchers have demonstrated common links between mental health

disorders and sexual functioning (Herder et al., 2023). There also is growing recognition of behavioral addictions and compulsive sexual behaviors related to sex, pornography, cybersex, and romantic love (Giordano, 2022). Additionally, psychological factors during the perinatal period, such as perinatal mood and anxiety disorders (PMADs), can impact sexuality for childbearing individuals (Lambregste-van den Berg & Pastoor, 2023). The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5-TR; American Psychiatric Association, 2022) contains three sections directly related to influences on sexuality: gender dysphoria (reviewed in Chapter 5), paraphilias (reviewed in Chapters 7 and 10), and sexual dysfunctions (reviewed in Chapter 10). Therefore, individual mental health functioning is an important contextual area for understanding human sexuality.

Physiology

Sex and sexuality have their origins within the body, from the anatomical body parts that determine one's biological sex, to the physical touching and connections involved in intimacy with another person, to how our physical health impacts our sexual functioning, and further to the physiological requirements of human reproduction (Althof, 2010; Levine, 2009; Pope et al., 2024a; Zeglin et al., 2018). Many counselors lack intensive training in biology and anatomy, and therefore, this aspect of sexuality can be intimidating as counselors may feel they lack the necessary medical knowledge to address physiological influences on clients' sexualities. Nonetheless, physiological components are essential for not only understanding human sexuality, but also for promoting clients' sexual health, pleasure, and overall wellness (Pope et al., 2024a). Further, counselors are likely to see clients with a variety of presenting issues that may impact their physiological sexual functioning, from clients coping with a recent medical diagnosis or infertility to clients experiencing fluctuations in sexual interest or responsiveness during the perinatal period, or clients encountering stigmatization or marginalization within the healthcare system. Therefore, counselors should equip themselves with a basic understanding of the physiological underpinnings of human sexuality, including sexual and reproductive anatomy, and seek information from medically reputable sources. To effectively address the physiological components of sexuality in counseling, collaboration with medical and healthcare providers is often necessary. Counselors also can advocate for inclusive spaces within the healthcare system and support legislation that upholds respect for diversity and bodily autonomy, increasing access to informed, culturally responsive, and trauma-informed healthcare for diverse populations across the lifespan.

Professional Issues in Sexuality Counseling

The area of sexuality counseling raises many questions for counselors, including how sexuality counseling differs from sex therapy, whether additional credentials are required, and what constitutes professional competence when practicing in this area. These issues can best be

understood within a historical context, and we begin this section by reviewing key historical and sociocultural developments that impact sexuality counseling practice today.

Historical, Societal, and Cultural Context

Perspectives on human sexuality within the mental health professions have shifted significantly over time. Some of the earliest medical and psychological views on sexuality were heavily influenced by Richard von Krafft-Ebing's publication of *Psychopathia Sexualis* in 1886, who primarily framed non-heteronormative sexual behaviors as abnormal or pathological (De Block & Adriaens, 2013; Drescher, 2015). Sigmund Freud also was hugely influential. Freud was one of the first psychologists to challenge the simplistic link between gender identity and sexual orientation. Although Freud viewed sexuality as a fundamental aspect of human development, his concepts of how sexual repression can contribute to mental health issues and sexual feelings as reflective of internal psychological conflicts still pathologized sexuality (Goodwach, 2005; Southern & Cade, 2011; De Block & Adriaens, 2013). These earliest conceptualizations of sexuality as unhealthy, unusual, or deviant continue to influence our sociocultural understandings of sex and sexuality today.

Sexuality, however, remained relatively understudied until the early 1900s. Henry Havelock Ellis and Magnus Hirschfield began shifting the study of sexuality, approaching their research from a more compassionate and open approach toward understanding sexual behavior and identity. Hirschfield founded the Institute for Sexual Science in 1919, which became a hub for progressive research on sexuality, and was one of the first to frame sexual health as a human right (De Block & Adriaens, 2013). Alfred Kinsey began his high-profile research in the 1940s and 1950s (Goodwach, 2005; Southern & Cade, 2011), which challenged many predominant norms about sexuality. Notably, Hirschfield's and Kinsey's work played a pivotal role in reshaping public views on affectional and sexual orientation, highlighting how sexual behaviors and attractions can vary over time and do not necessarily conform to a rigid homosexual/heterosexual binary (Drescher, 2015).

Following Hirschfield and Kinsey, and led by the work of William Masters and Virginia Johnson, sex therapy emerged as a formalized field, predominantly focused on behavioral approaches to address sexual dysfunction (Goodwach, 2005; Southern & Cade, 2011). The term *sex therapy* was first used in the 1950s by Masters and Johnson, although it was not used widely until the 1970s (Binik & Meana, 2009). Though recognition of gender diversity began in the late 1800s and early 1900s throughout Western Europe, influenced by the work of Freud, Havelock Ellis, and Hirschfield, gender diversity did not receive widespread attention until an American GI, Christine Jorgensen, received sexual reassignment surgery in 1952 (Reicherzer, 2008). Jorgensen's transition prompted more medical and psychological research on gender diversity (at the time was termed "transsexualism") throughout the following decades. From the late 1950s to the 1970s, American culture at large also experienced a significant period of sexual exploration and experimentation (Goodwach, 2005). This resulted in a range of humanistic approaches (e.g., surrogate partners, nudism, mind-body approaches, and counselors

using sexual touch with clients) (Tiefer, 2006), many of which are no longer accepted as ethical practices today.

During this period, the first *Diagnostic and Statistical Manual of Mental Disorders* was published by the American Psychiatric Association in 1952. A variety of sexual dysfunctions have been included in the DSM since its inception, such as diagnoses of "sexual impotence," "dyspareunia" (pain during sexual intercourse, which was the early diagnosis for genito-pelvic pain disorder in the DSM-5-TR), and "leukorrhea" (vaginal discharge) (DeBlock & Adriaens, 2013). The early versions of the *DSM* also included the diagnosis of "homosexuality," classified first as a "sociopathic personality disturbance" in the *DSM-I* (Drescher, 2015). The DSM-II introduced "sexual deviations," including homosexuality, and others that remain in the DSM-5-TR (American Psychiatric Association, 2022) today, reclassified as "paraphilias:" fetishism, exhibitionism, voyeurism, pedophilia, sadism, and masochism (DeBlock & Adriaens, 2013).

It is unsurprising, given the early iterations of the *DSM*, that early sex therapy in the 1970s focused on dysfunction-specific treatments that typically integrated educational approaches combined with behavioral and communication-based interventions (Binik & Meana, 2009; Meana et al., 2020). In particular, Dr. Helen Singer Kaplan's approach in the 1970s integrated medical and psychological approaches with sex therapy (Southern & Cade, 2011). The emerging U.S. LGBTQ+ rights movement in the late 1960s and early 1970s led to the removal of homosexuality as mental disorder from the *DSM* in 1973 (Drescher, 2015) and started a sociocultural shift toward increased social acceptance toward and civil rights protections for LGBTQ+ communities (Balestrery, 2017). A new category of sexual dysfunctions first appeared in the *DSM-III* in 1980 (Binik & Meana, 2009), alongside introducing the diagnosis of "gender identity disorder" (Reicherzer, 2008). Sexuality moved further into the mainstream of social dialogue in the United States in the 1980s with the publication of several high-profile sexual self-help books and numerous TV personalities (e.g., Dr. Ruth) emerging on different media platforms (Binik & Meana, 2009; Southern & Cade, 2011).

Since the 1960s and 1970s, the fields of sexology and sex therapy has experienced significant growth. The American Association of Sexuality Educators, Counselors, and Therapists (AASECT) was established in 1967, alongside multiple national and international associations dedicated to the study and promotion of sexual health. Similarly, professional and advocacy-based organizations focused on the health of LGBTQ+ communities were formalized, such as the establishment of the World Professional Association for Transgender Health (WPATH) in 1979. The work of these organizations, alongside civil rights movements globally, contributed to establishing sexual health as a basic human right (WHO, 2024).

Moving further into the 1980s and 1990s, sex therapy experienced a shift toward medical approaches to treating sexual dysfunction, especially with a series of highly publicized medications designed to treat erectile dysfunction, such as Viagra (Goodwach, 2005; Krakowsky & Grober, 2018; Tiefer, 2006). By and large, conceptualizations of sexuality throughout the 20th century were grounded in heteronormative sexuality (Marshall, 2002) and the medical model, emphasizing the diagnosis and treatment of sexual dysfunctions and so-called "abnormal" sexual behavior. The medicalization of sexuality has received pushback from sex therapists and feminist scholars (Nicholls, 2008; Southern & Cade, 2011), arguing that the medical model often

reinforces a sex-negative perspective, situating any sexual activity and sexuality that is outside of the dominant norms (e.g., heteronormative, monogamous, procreative, orgasm-focused sex) as inherently problematic or deviant (Cruz et al., 2017; Tiefer, 2001; Zeglin et al., 2019). Further, advocates argue that the full scope of human sexuality and eroticism is difficult to capture in empirical medical approaches to research (Tiefer, 2001), which has led to the alternative framework of positive sexuality (i.e., sex positivity) that normalizes diverse sexual expressions and situations sexuality within a relational and sociocultural context (Burnes et al., 2017; Cruz et al., 2017; Zeglin et al., 2019).

The fields of sexology and sex therapy have evolved further since the early 2000s. A major development is the shift from an individualized, behavioral approach toward understanding and treating sexual concerns from a systemic lens (Goodwach, 2005). For instance, a grassroots initiative called the New View Campaign was launched in 2007 by feminist scholars and sexologists, with the goal of creating an alternative framework for understanding women's sexual concerns (Nicholls, 2008; Southern & Cade, 2011). The fundamental tenet of the New View is that women's sexual functioning can best be understood within their relational context, emphasizing how sociocultural, political, and economic factors can impact women's sexuality (Southern & Cade, 2011). The integration of critical theories into sexology further centers the systemic context, and how intersecting experiences of historical, sociocultural, and political oppression impact sexual health as a human right. For individuals of marginalized backgrounds, oppressive systems impact their access to healthcare, sex education, and community resources that promote their autonomy, ability to make informed decisions, and sexual satisfaction and pleasure. Additionally, through degrading their dignity and agency, oppression contributes to an increased risk of discrimination, violence, and exploitation for marginalized populations. Hence, organizations such as the World Association for Sexual Health (WAS, 2023) center social justice work, often termed *sexual justice,* toward transforming systemic inequities and structural conditions that invalidate sexualities, perpetuate violence, and diminish the sexual health of marginalized communities.

Other recent advances include the use of mindfulness-based approaches and trauma-informed practices. Further, the Internet has increased access to sexuality counseling through telemental health treatment options, as well as the availability of sexual health information (Southern & Cade, 2011). Ongoing medical advancements can offer new opportunities for counselors to train medical professionals about sexuality and relationships (Pukall & Reissing, 2007), so collaboration with medical and healthcare providers remains a key role for sexuality counselors. The highly medicalized approach to treating clients' sexuality concerns has problems and limitations, namely in the pathologization of diverse sexual expressions and focusing on treating sexual dysfunctions rather than preventative care to enhance sexual health (Cruz et al., 2017; Zeglin et al., 2019). However, medical interventions can still be beneficial to clients, particularly when integrated with therapy to address related psychological, emotional, and relational factors impacting clients' sexual health (Binik & Meana, 2009). Medical advances also raise the public profile of the topic of sexuality, such that members of the general population may become more inclined to seek all forms of treatment for their sexual concerns. Within the relatively short history of sexology and sex therapy, there have been numerous and significant

changes in the assumptions and practices that guide caring for clients. At the same time, there has been a growing emphasis on the professionalism of the field, as evidenced by the current availability of the professional credentials and guidelines discussed in the following sections.

Credentialing and Professional Identity Issues

Professional organizations and credentialing help to ensure that a profession maintains high standards and protects client welfare. In addition, credentialing requires that professionals meet minimum training and experiential requirements specific to sexuality, and professionals without credentials have no such guaranteed minimal requirements (Kleinplatz, 2009). Although credentials are available for sexuality counselors and sex therapists, these areas of practice generally are not regulated by state licensure bodies, and therefore, there is less oversight of practice in these areas than in general mental health professional licensure (Binik & Meana, 2009; Meana et al., 2020).

Distinguishing Between Sexuality Counseling and Sex Therapy

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

> Counselors assist the client to realistically resolve concerns through the introduction of problem-solving techniques of communication as well as providing accurate information and relevant suggestions of specific exercises and techniques in sexual expression. Sexuality counseling is generally short-term and client-centered, focusing on the immediate concern or problem. (para. 8)

The Association of Counseling Sexology and Sexual Wellness (ACSSW, 2019a) further defines sexuality counseling 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. (What is Sexuality Counseling? section)

As relayed in these definitions of sexuality counseling, many of the tools used in sexuality counseling overlap with those counselors generally employ to address a variety of presenting concerns, such as facilitating clients' self- and other-awareness, providing psychoeducation, and using practical interventions like mindfulness or skills training. Within sexuality counseling, sex

and sexuality may not be the primary presenting concern of clients, but rather an ancillary area of attention toward their overall counseling goals. For example, a client presenting with depression may simultaneously experience a drop in sexual desire, impacting their intimate relationship. The focus of counseling would be improving this client's symptoms of depression, with a secondary focus on eliciting their partner's support and finding other ways to navigate physical intimacy while working toward improvements in their mood.

Contrastingly, sex therapy is a deeper, longer-term therapeutic process in which the primary focus of intervention is typically related to the client's presenting concerns regarding sex or sexuality. AASECT (n.d.) defines sex therapists as:

> licensed mental health professionals, trained to assess, diagnose, and provide in-depth psychotherapy, who have specialized in treating clients with sexual issues and concerns. Sex therapists work with sexual concerns, including but not limited to: sexual function and dysfunction; sexual pleasure; sexual variation; sexuality and disability; sexuality and chronic illness; sexual development across the lifespan; sexual abuse, assault, and coercion; sexual orientation; gender identity. In addition, where appropriate, are prepared to provide comprehensive and intensive psychotherapy over an extended period of time in more complex cases. (para. 9)

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

Is Sexuality a True Specialty Area?

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

In response to Binik and Meana (2009), Kleinplatz (2009) wrote that credentialing in the area of sex therapy and sexuality counseling serves the primary and important function of

protecting clients. In particular, due to the general lack of training in sexuality among most mental health professionals, in combination with the proliferation of inaccurate and biased information that exists in society, there is a high potential for harm when clients seek treatment related to sexuality from inadequately trained professionals (Kleinplatz, 2009). Kleinplatz cited anecdotal evidence that credentialed therapists often work with clients who have been harmed by other, inadequately prepared professionals when they practice outside of the bounds of their competence. Kleinplatz goes on to suggest that until all mental health and other healthcare professionals receive adequate training in sexuality as part of their professional preparation, specialized credentials are needed. Tiefer (2009) also responded to Binik and Meana (2009) and suggested that a specialization related to sexuality is necessary because sexuality is an inherently and extensively complicated issue that faces unique social, political, and relational contexts as compared to other areas of mental health practice.

Despite the dialogue regarding whether sexuality counseling and sex therapy are justified as being considered unique specialization areas, both professionals and the general public continue to view sex therapy as a specialized discipline (Binik & Meana, 2009; Meana et al., 2020). Counselor education programs still neglect sexuality as a primary training area for counselors, with only 15% of clinical mental health counseling programs requiring a course on sexuality (Pope et al., 2024b). The availability of professional training programs for professionals interested in working as sex therapists or sexologists, as well as specialized professional journals, add to the general view that these areas require specialized training and educational experiences. As explored throughout the rest of this section, there have been recent advancements in the counseling profession toward recognizing the need for *all* counselors to be prepared to address topics of sex and sexuality with their clients, with the recognition that sexuality is a central facet of the human experience. Regardless of training and experience, counselors are going to encounter the topics covered in this book with their clients. At a minimum, counselors need the foundational knowledge and skills to prevent harming their clients when these sensitive and vulnerable areas arise in the therapy room.

Relevant Professional Organizations

Counselors interested in gaining additional information and professional networking opportunities may wish to become involved with AASECT and/or other professional associations related to sexuality. AASECT holds an annual conference and offers other such benefits as a referral service, list-serv, professional training, and advocacy. Beyond AASECT, 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, 2019b, Mission section) in diverse communities.

Other relevant organizations are the World Association for Sexual Health (WAS), Sexuality Information and Education Council of the United States (SIECUS), the Society for

Advancement of Sexual Health (SASH), the Society for the Scientific Study of Sexuality (SSSS), and the Society for Sex Therapy and Research (SSTAR). All of these organizations are very interdisciplinary and provide potentially valuable resources for sexuality counseling.

Credentialing Options

Currently, AASECT is the primary pathway to certification in sexuality counseling or sex therapy. AASECT offers credentialing as a certified sexuality counselor and as a certified sex therapist, in addition to their certified sexuality educator and supervisor credentials for those who do teaching and training about sex and sexuality. Both the AASECT sexuality counselor and sex therapist certifications require a combination of professional requirements (e.g., membership in AASECT and adherence to the AASECT Code of Conduct), educational requirements, direct practice (i.e., clinical work) under appropriate supervision, and training experiences addressing personal attitudes and values related to sexuality (AASECT, n.d.). Licensed mental health counselors are eligible for both the sexuality counselor and sex therapist credential. Other mental health professionals, including school counselors, nurses or healthcare professionals, and clergy, may qualify for the sexuality counselor credential. AASECT also offers sexuality educator and supervisor credentials for counselors who wish to expand their discipline beyond clinical practice (AASECT, n.d.). Readers interested in these credentialing options are encouraged to consult the AASECT website for the most current information regarding credentialing requirements.

ACSSW is currently working on developing an introductory training program in sexuality counseling, which can help expand training in sexuality to counselors who did not receive this education in their master's programs. Consult the ACSSW website for future updates on their training pathway.

Professional Competence in Sexuality Counseling

Ethically, counselors must always practice within the bounds of their professional competence, meaning they should only provide services where they have the necessary knowledge, skills, and experience (AASECT, 2020; ACA, 2014; American Psychological Association [APA], 2017). Therefore, professionals must understand their own level of preparedness to address sexuality-related issues in their work, based on their education, training, and supervised experience. Whether or not they seek a specialized credential in this area, all counselors should be equipped with a basic understanding of sexuality issues, as sexuality is a core aspect of the human experience. Further, counselors should be aware of where to refer clients for issues that extend beyond the scope of their practice. Again, clients in any clinical setting may experience sexuality-related problems or other concerns that impact their sexual functioning. However, existing research suggests that most mental health professionals feel underprepared to address sexuality issues in counseling, in large part due to a lack of training and experience in this area of therapeutic practice (Behun et al., 2017; Harris & Hays, 2008; Wilson, 2019).

We cannot overstate the importance of counselors seeking out continual training and experience to foster their preparedness in the area of sexuality counseling. Education and

supervision can address personal discomfort and value conflicts that may interfere with counselors' abilities to effectively provide sexuality counseling services (Behun et al., 2017; Emelianchick-Key et al., 2021; Wilson, 2019). To assist readers in determining their current level of competence for sexuality counseling and in identifying areas for further growth, we provide the following checklist of the core components of sexuality counseling in Exercise 1.1 (Kazukauskas & Lam, 2009; Pope et al., 2024a; Southern & Cade, 2011; Zeglin et al., 2018).

Exercise 1.1 What Is Your Current Level of Competence in Sexuality Counseling?

Consider the following questions that reflect different aspects of competence in sexuality counseling as related to the Contextualized Model of Sexuality. Circle "Very," Somewhat," or "Not at All" in response to each question. The questions for which you answered "Somewhat" or "Not at All" are indicators of areas in which you may benefit from seeking additional training, supervision, experience, and/or information about local and national resources as you develop your competency in sexuality counseling.

1. Are you comfortable talking about sex and sexuality with clients? Very/Somewhat/Not at all
2. Are you knowledgeable about appropriate assessment strategies to assess sex and sexuality with clients? Very/Somewhat/Not at all
3. Are you knowledgeable about general treatment strategies to use in counseling to address client's concerns related to sex and sexuality? Very/Somewhat/Not at all
4. Can you describe how sociocultural influences impact clients' sexuality? Very/Somewhat/Not at all
5. Can you describe the basic sexuality-related tasks associated with each area of lifespan development (e.g., early and middle childhood, adolescence, and young, middle, and older adulthood)? Very/Somewhat/Not at all
6. Are you knowledgeable about gender diversity and gender-affirming counseling? Very/Somewhat/Not at all
7. Are you knowledgeable about affectional and sexual orientation and affirming counseling practices? Very/Somewhat/Not at all
8. Are you knowledgeable about diverse sexual expressions and communities, including but not limited to consensual non-monogamy, kink practices, and bondage, discipline, dominance, submission, sadism, and masochism (BDSM)? Very/Somewhat/Not at all
9. Do you understand how sexuality plays a role in the development and maintenance of intimate relationships? Very/Somewhat/Not at all
10. Do you understand the basics of how trauma can impact sexuality and sexual functioning, such that you could describe these to clients? Very/Somewhat/Not at all
11. Do you understand the impact that common mental health problems (e.g., anxiety, depression, traumatic stress, substance use) can have on clients' sexuality? Very/Somewhat/Not at all
12. Do you understand the basics of human anatomy and physiology related to sex and sexuality, such that you could describe these to clients? Very/Somewhat/Not at all

13. Do you have the training and experience to provide relationship, couple, and family counseling services? Very/Somewhat/Not at all
14. Are you knowledgeable of and connected to referral sources for clients whose sexuality-related concerns are beyond your competence? Very/Somewhat/Not at all
15. Do you feel prepared to engage in systemic advocacy to promote positive sexuality and remove barriers to sexual health for diverse populations? Very/Somewhat/Not at all

Another framework to help counselors decide if and when to refer clients whose concerns reach beyond their scope of practice is Annon's (1976) P-LI-SS-IT Model. This model's name stands for Permission – Limited Information – Specific Suggestions – Intensive Therapy. At the first level of Permission, counselors create the opportunity and space for clients to discuss their sexuality concerns. Second, the Limited Information level involves counselors offering clients accurate sex information and the chance to explore the sociocultural messages surrounding clients' concerns. The third level of Specific Suggestions involves treatment planning and goal setting with clients to address their sexuality concerns. Counselors use specific interventions to meet clients' needs, integrating strategies focused on physiology, mental health, relationships, and/or systemic advocacy. At the final level of Intensive Therapy, counselors provide in-depth treatment to address the full complexity of clients' concerns. Counselors must consider how their training and experience have adequately equipped them to provide services to clients at each level (Southern & Cade, 2011).

The question of when counselors should refer clients for specialized treatment (e.g., to a certified sex therapist) is a complicated one. Counselors must consider carefully whether they are referring out of personal discomfort or values rather than based on what is in the best interest of the client (ACA, 2014; Binik & Meana, 2009). Clients may feel that their concerns are being dismissed by the original counselor if they are immediately referred for sex therapy (Binik & Meana, 2009). When clients' sexual concerns fall clearly outside of counselors' level of professional competence, a referral to a sex therapist is most likely warranted. Generally, sexuality counselors are equipped to provide care to clients at the first three levels of Annon's model (P-LI-SS), whereas sex therapists also are prepared to work with clients at the fourth level of Intensive Therapy. Referrals to sex therapy must be handled with care to ensure that clients understand the rationale for referral and that their needs are centered during the transfer process.

Cultural Humility

According to the ACA (2014) Code of Ethics, "multicultural counseling competency is required across all counseling specialties" (C.2.a). To work effectively with diverse populations, counselors must integrate *both* cultural competence and cultural humility (Stubbe, 2020). Competency centers the counselors' development of awareness, knowledge, and skills; hence, outcomes focus on the counselors' ability to learn and self-efficacy toward working with diverse populations. Conversely, *cultural humility* positions clients as the primary source of knowledge, recognizing that effective therapy involves counselors engaging in an ongoing process of self-reflection,

openness, and learning from clients' lived experiences (Lekas et al., 2020). Cultural humility emphasizes shared power and active collaboration with clients, recognizing the importance of working together to navigate and challenge systemic oppression (Fisher-Borne et al., 2015; Lekas et al., 2020).

Cultural humility is a critical component of sexuality counseling for several reasons. Firstly, counselors who operate from a lens of cultural humility are less likely to assume their own experiences or values regarding sexuality are universal, reducing the risk of invalidating or pathologizing clients' experiences. Secondly, cultural humility encourages counselors to approach their clients' unique sexualities from a place of curiosity and nonjudgment; hence, central to cultural humility is an openness to sexual diversity. Thirdly, given the sensitive nature of sexuality as a topic for many clients, cultural humility prioritizes creating a safe, affirming space where clients feel comfortable exploring sex and sexuality without fear of shame or rejection. Finally, cultural humility acknowledges how sociocultural, political, and systemic factors impact clients' sexual health, and emphasizes the need for counselors to consider the broader context, such as experiences of discrimination, marginalization, and oppression, that can shape clients' sexual experiences and well-being. For counselors to work from a culturally humble perspective, *critical introspection* is key to exploring how one's own beliefs, values, and biases that may interfere with the therapeutic process (Pope et al., 2024b).

Personal Values: The Importance of Critical Introspection

In the realm of sexuality, counselors must be careful to avoid confusing personal values that conflict with clients' choices for a lack of competence. Counselors are ethically bound to provide services without discriminating against clients based on "age, culture, disability, ethnicity, race, religion/spirituality, gender, gender identify, sexual orientation, marital/partnership status, language preference, socioeconomic status, immigration status, or any basis proscribed by law" (ACA, 2014, C.5). This can certainly present challenges to counselors if they hold personal beliefs that conflict with clients' identities, culturally derived sexual norms, or other sexual expressions and practices.

Some states have instituted religious exemption laws that conflict with the ACA Code of Ethic's (2014) non-discrimination policy, creating a potential conflict between counselors' professional responsibilities and discriminatory practices sanctioned by state law. Religious exemption laws, or "conscience clauses," can allow therapists and other healthcare professionals to deny services based on specific aspects of clients' identities, namely gender identity and affectional or sexual orientation, based on the counselors' religious or personal beliefs (APA, 2020). Multiple mental health professional organizations, including ACA (Kaplan, 2014) and APA (2020), have unequivocally denounced religious exemption laws that protect healthcare providers' personal beliefs as discriminatory and counter to our professional commitments to diversity and inclusion of protected classes.

All counselors, however, hold personal beliefs and values that can impact our work with clients; therapeutic work is inherently subjective, and counselors cannot completely suspend their values, including religious beliefs, when working with clients. Within sexuality counseling,

there are multiple values conflicts that can arise beyond views on gender identity and affectional or sexual orientation, including views on abortion, contraception, and reproductive healthcare; beliefs about monogamy, multiple sexual partners, and general views on intimate relationships; or perspectives on what constitutes "normal" or acceptable sexual expressions behavior. Hence, it is counselors' responsibility to ensure their personal biases do not interfere with their ability to provide competent and ethical care, which includes how to affirmingly navigate referrals when warranted based on counselors' skill-based competency (Kaplan, 2014; Kocet & Herlihy, 2014).

Simply referring clients whose sexual identities, expressions, or practices are uncomfortable to counselors has a great potential for harming clients (Priest & Wickel, 2011; Cruz et al., 2017). Certain client populations, such as LGBTQ+ individuals, those engaging in consensual non-monogamy, or people with diverse sexual expressions and practices, have historically felt marginalized from psychotherapy (Berke et al., 2016; Burnes et al., 2017; Mosher, 2017; Sprott et al., 2021; Swindlehurst et al., 2024). As therapeutic settings mirror sociocultural attitudes, counselors should make extra efforts to ensure their treatment settings are affirming and responsive to clients' needs, particularly for clients who are likely to experiencing marginalization in the larger social context (Cruz et al., 2017).

Managing internal reactions is part of an ongoing critical introspection for counselors, and if navigated effectively, internal reactions can be prevented from negatively impacting the counseling relationship. However, the likely impacts of negative non-verbal responses or microaggressions include clients feeling judged or condemned, losing trust in the counselor, choosing to not disclose additional personal information, or opting to terminate counseling (Berke et al., 2016; Cruz et al., 2017; Sprott et al., 2021; Swindlehurst et al., 2024). Therefore, counselors must be aware of possible values and biases that they bring to the counseling relationship (Cruz et al., 2017; Emelianchick-Key et al., 2021; Pope et al., 2024a; Sanabria & Murray, 2018). Through critical introspection, clinical supervision, and ongoing consultation, counselors should examine their biases and the extent to which these may impact their responsiveness in treating certain client populations (ACA, 2014; Cruz et al., 2017; Sanabria & Murray, 2018). Ultimately, it is counselors' professional responsibility to center the welfare of their clients, regardless of their own personal values, while navigating the complexities of the law and ethical codes with professionalism and integrity.

Exercise 1.2 Critical Introspection Exercise: Sexuality and Values

Respond to each of the items below with two to three sentences describing your beliefs related to common areas in which society and people hold strong, and often negative or shame-based, values around sexuality. Be as honest and transparent as possible. You can journal your responses and/or process with a trusted colleague or supervisor.

1. I define sex as...

2. I believe healthy sexuality entails...
3. I believe children should begin to learn about sex when...
4. I believe that abstinence-only education is...
5. I believe that masturbation is...
6. I believe bisexual people are...
7. I believe transgender people are...
8. I believe intimate relationships should be...
9. I believe people who have sex with multiple partners are...
10. I believe people who do not have children are...
11. I believe that pre-marital sex is...
12. I believe that people who cheat on their partners are...
13. I believe that viewing pornography is...
14. When I think about individuals with disabilities having sex, my reaction is...
15. When I think about older adults having sex, my reaction is...
16. I believe people who contract sexually transmitted infections are...
17. I believe abortion is...
18. If my client disclosed they had *experienced* a sexual assault, my reaction would likely be...
19. If my client disclosed they had *committed* a sexual assault, my reaction would likely be...
20. If my client disclosed they are sexually attracted to minors, my reaction would likely be...

After reviewing your beliefs and values identified in the items above, consider the following questions:

1. What sexuality-related topics may be the most comfortable for me to work with as a counselor?
2. What topics may be the most difficult for me to work with as a counselor?
3. With which types of clients do you believe you would be most and least comfortable talking about sexuality? What factors make you more or less comfortable with each population?
4. What is one goal I can set for myself related to developing my comfort in working with sexuality-related topics with clients?

The Ability to Talk Professionally and Comfortably About Sexuality

Sex and sexuality are often very difficult topics to discuss, whether personally or in a professional context. Although many mental health professionals lack comfort in talking about sexuality-related issues with clients, sexuality is a significant and natural part of life that all counselors must strive to develop comfort and competence to address in their work (Emelianchick-Key et al., 2021; Wilson, 2019). As Binik and Meana (2009) stated, "If sex, the very activity that perpetuates human life, is a source of paralyzing anxiety for a would-be mental health practitioner, then something is wrong with our professional training" (p. 1023). A valuable question to yourself is: *Which aspects of sexuality are you more and less comfortable discussing?* Given conflicting societal

messages and a general lack of education on sexuality, it is likely that every single person has certain sexuality-related topics that they would be at least somewhat anxious to talk about with others. Some counselors may feel wholly uncomfortable with the topic of sexuality, while others may experience discomfort in just a few specific topic areas. Nonetheless, existing research suggests that self-reflection and feeling comfortable talking about sexuality may be even more important than knowledge in counselors' ability to raise the issue of sexuality with their clients (Harris & Hays, 2008; Wilson, 2019).

Counselors therefore should strive to increase their comfort in talking about sexuality in a professional context. Several activities can help to promote this comfort, including those throughout this text. First, counselors should practice engaging in these discussions during training exercises, clinical supervision, and professional consultation (Wilson, 2019). Second, counselors should develop a culturally responsive vocabulary to use when discussing sexuality issues. As will be discussed later in this book, it is important for counselors to use language that is in line with clients' worldviews, identities, and sociocultural contexts. Overly clinical and technical language can decrease the emotional aspects of clients' experiences, whereas overly informal language may be interpreted as crude or offensive by clients. Third, when addressing sexuality concerns with clients, counselors must strike a balance between the professional boundaries in place and the personal impact of this work (Nijs, 2006). Counselors of course cannot deny their humanity and are likely to be impacted personally by their work related to sexuality, especially when working with clients impacted by sexual trauma or exploitation. Hence, it is critical for counselors to attend to their own personal wellness when working with clients on sexuality-related issues (Nijs, 2006). Finally, counselors should engage in ongoing reflection to examine their personal barriers to becoming comfortable discussing sexuality, as well as seek out consultation and supervision for support and to identify strategies to enhance their comfort with sexuality-related topics (Pope et al., 2024a).

Ethical Considerations for Sexuality Counseling

Sexuality counseling presents counselors with unique ethical considerations that reflect the sensitive and personal nature of the subject of sexuality. In this section, we draw upon two primary ethical codes, that of ACA (2014) and AASECT (2014). Mental health professionals from other disciplines must be sure that they are following the ethical guidelines of their professional associations, as well as all legal regulations. As legal statutes related to sexuality counseling vary from state-to-state, covering the scope of laws is outside of the purview of this text. Examples of legislation that impacts the practice of sexuality counseling include age of consent to mental health services, confidentiality exceptions related to the transmission of communicable and life-threatening diseases such as STIs, religious exemption laws, and restrictions on gender-affirming care. Counselors are responsible for familiarizing themselves with the laws in their state(s) of residence and licensure regarding sexuality counseling practice.

In addition to the ethics of the competence issues already reviewed above, the ethical issues reviewed in this section are as follows: ethical sexual behavior, client vulnerability, client

confidentiality and secrets, and sexual or romantic misconduct. We also recommend counselors familiarize themselves with professional guidelines, which are best-practice recommendations for counselors specific to various areas of counseling. The ACSSW Exemplary Practices for Counseling Sexology and Sexual Wellness (Pope et al., 2024a) offer overarching guidelines for mental health professionals to enrich sexuality counseling practice and engage in systemic advocacy toward promoting the sexual health of their clients. Additional ethical considerations, current legislation, and professional guidelines are discussed throughout this book in the relevant chapters. Counselors are advised to seek continuing education to maintain an ongoing focus on addressing these ethical concerns throughout their careers.

Principles of Ethical Sexual Behavior

Healthy sexual behavior is ethical, in that it balances both sexual rights and personal accountability. Seven principles of ethical sexual behavior are as follows (AASECT, 2013; Braun-Harvey & Vigorito, 2015; Darling & Mabe, 1989; Pope et al., 2024a; SIECUS, 2004; Southern, 2018):

Consent: Emphasizing consent, individuals should have full ability to choose for themselves whether, when, and how they wish to engage in sexual activities. Further, consent can change from moment to moment and be revoked at any time.

Autonomy: Individuals have the right to make bodily and sexual choices that promote their sexual wellness. Individuals should not treat others solely as means to an end, namely that they should not be used merely for another person's personal sexual gratification.

Integrity: Individuals should be honest and not withhold information that diminishes others' consent and autonomy. Individuals should have full information available to them when deciding whether to engage in sexual activities.

Responsibility: Individuals are accountable for their sexual choices and behaviors and refrain from engaging in practices that harm themselves or others.

Respect for others' beliefs and differences: Individuals hold regard for others' sexual beliefs, values, expressions, and identities without attempting to force or coerce change.

Freedom to change: Individuals recognize that sexuality is fluid throughout the lifespan. Individuals encourage others' autonomy to make bodily and sexual choices that enhance their sexual wellness.

Reverse sex negativity: Individuals act to diminish shame, stigma, and the pathologization of sex and sexuality.

Pleasure and mutual pleasure: Individuals appreciate that giving and receiving pleasure is a primary motivator for most people who engage in solo or partnered erotic activities.

Ethical sexual behavior is grounded in the regard for sexual health as a basic human right. The foundation of ethical sexual behaviors is respect for others, including their right to

privacy, equality, nondiscrimination, nonviolence, information, safety, autonomy, and freedom of opinion and expression (WHO, 2024). As WHO (2024) states, "The responsible exercise of human rights requires that all persons respect the rights of others" (para. 5). Hence, the ethical sexual behavior framework is critical for counselors to use to a) not impose their own values and beliefs on their clients, and b) assess that clients' sexual behavior is healthy insofar as it respects their own rights and the rights of others. Counselors must consider each of these ethical principles as they help their clients navigate the sexuality concerns they bring to counseling, recognizing that sexuality is often a sensitive aspect of people's lives and relationships. This sensitivity can contribute to a unique level of vulnerability for clients when discussing topics of sex and sexuality in counseling.

Client Vulnerability

The AASECT (2014) Code of Conducts even states, "Given that consumers are in unique and vulnerable positions with respect to the sensitive nature of services… certified members shall constantly be mindful of the responsibility for the protection of the consumer's welfare, rights and best interests and for the rigorous maintenance of the trust implicit in the consumer relationship" (p. 7). Sociocultural attitudes toward sex continue to be negative, silencing and suppressing sex as a normative part of the human experience. People are likely to internalize these sex-negative messages, carrying shame and discomfort about their sexual practices, histories, and experiences (Burnes et al., 2017; Cruz et al., 2017). To begin to understand the nature of the vulnerability of clients in counseling discussing their sexual concerns, we encourage readers to pause reading in order to do the following guided reflection exercise on client vulnerability.

Exercise 1.3 Guided Reflection Exercise: Client Vulnerability in Sexuality Counseling

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

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

Third, consider how you would feel speaking about this aspect of your sexuality with a professional counselor. Ask yourself, "Would I tell my counselor about this aspect of myself? If I were to tell my counselor about this aspect, what would I think or feel as I share? What would I be looking for in how my counselor reacts to me?"

Counselors must be proactive in creating a counseling environment in which clients can feel safe and supported in discussing some of their most personal thoughts, feelings, and experiences.

In addition to building a strong rapport with and centering clients' needs, three fundamental ethical principles can guide counselors in creating this supportive environment. First, it is important for counselors to maintain professional boundaries at all times when engaging in sexuality counseling (AASECT, 2020, Principle 2; ACA, 2014, A.6). A clear professional boundary can help assure the client that the counselor is competent and prepared to address the client's sexuality concerns in an ethical and professional manner. Second, sexuality counselors must avoid imposing their values on their clients (AASECT, 2020, Principle 3.1.d; ACA, 2014, A.4.b). Sex is an extremely value-laden issue. Because counselors have a powerful position with regard to their level of influence on their clients, they must be extremely careful to ensure that they do not use this privileged position to sway clients toward their own personal value systems. Third, counselors should respect clients' autonomy for their own lives and decisions. The ACA (2014) Code of Ethics states that counselors' primary ethical responsibility is "to respect the dignity and to promote the welfare of clients" (A.1.a). Therefore, on the one hand, clients in sexuality counseling can be considered vulnerable because of the sensitive nature of the topic of sexuality. However, counselors must bear in mind that their role is to help their clients make decisions and behavioral changes that support their own life goals, even if the counselor has reason to believe that behavior may have negative consequences. Exceptions to confidentiality in issues such as this are discussed below.

Client Confidentiality and Secrets

Client confidentiality issues are especially relevant for sexuality counseling, given the sensitive nature of the subject. When there are possible legal implications of the clinical work, counselors should be especially mindful of client confidentiality issues. As in all counseling, the limitations to confidentiality should be discussed clearly with clients at the outset of therapy (ACA, 2014; APA, 2017). As discussed above, counselors must respect clients' autonomy. However, there may be cases in which counselors view clients' decisions as having potentially harmful consequences for themselves or for others. The decision whether to break confidentiality in such cases must be made carefully and through consultation with other professionals (ACA, 2014), including possibly seeking legal advice. When there is a risk of severe harm, as in a threat of suicide or homicide, breaking confidentiality is ethically justifiable (AASECT, 2020; ACA, 2014).

However, the ethical response to some sexual issues is less clear. For example, a client may disclose that they intend to coerce their partner(s) into sexual activity. Disclosing this information to the partner(s) (especially when the partner(s) are not a client in conjoint treatment) is a more ambiguous issue. The AASECT (2020) Code of Ethics states that confidential information may be disclosed "when there is clear and imminent danger of bodily harm or to the life or safety of the consumer or another person" (Principle 3.4.b). This client's counselor will need to gather additional information and consult with colleagues to determine if a disclosure is warranted.

Sexually transmitted infections (STI) are another related concern, and the ACA (2014) Code of Ethics says the following:

When clients disclose that they have a disease commonly known to be both communicable and life threatening, counselors *may* [emphasis added] be justified in disclosing information to

identifiable third parties, if they are known to be at demonstrable and high risk of contracting the disease. (B.2.b)

The use of the word "may" in the standard above indicates that there is substantial room for interpretation in these cases. Counselors in this situation must weigh the severity of the diagnosis and the STI and the ability to identify the third parties at risk of contracting the STI. As with any decision to break confidentiality, counselors should follow all relevant laws in their jurisdictions of practice.

Another ethical consideration that may arise when working with clients around sexuality issues is whether and how counselors should keep secrets for clients in conjoint relationship counseling. Common secrets that may arise in couples and relationship therapy related to sexuality include infidelity, hidden addictive behaviors (e.g., hypersexuality or substance use), diverse sexual or erotic attractions not disclosed to their partners (Corley & Schneider, 2002; Mark & Schuman, 2020). Other secrets, such as undisclosed mental health struggles or hiding financial habits, also may impact the partners' relational intimacy. Counselors should have a clear, written policy related to how they handle secrets as part of their informed consent for relational counseling (Mark & Schuman, 2020). In general, keeping secrets for clients can be difficult for therapists and damaging to the therapeutic relationship. Keeping a secret may be warranted in some situations, particularly when disclosure could lead to abuse or violence or when a significant amount of time has passed since the events occurred (Mark & Schuman, 2020). When appropriate, therapists can work toward disclosure of the secret by the client during sessions to facilitate appropriate processing of the disclosure with their partners and provide a supportive context for the revelation of the previously undisclosed information (Corley & Schneider, 2002).

Sexual or Romantic Misconduct

Sexual or romantic relationships with clients, their partners, or their family members are harmful to clients and are unethical (ACA, 2014; APA, 2017; MacIntyre & Appel, 2020). Sexual and romantic misconduct with clients is a violation of the trust that clients place in their counselors. This misconduct can have devastating impacts on clients, including negative emotional consequences, such as shame, posttraumatic responses such as dissociation and nightmares, and increased risk for suicide attempts (Courtois et al., 2021; MacIntyre & Appel, 2020). Additionally, sexual or romantic misconduct can isolate clients form their social relationships and prevent clients from seeking additional counseling in the future (Steinberg et al., 2021). As with other forms of abusive behavior, clients may still have positive or ambivalent feelings toward their therapists that perpetuated the misconduct (Courtois et al., 2021). It is not only the counselors who engage in romantic or sexual misconduct with their clients that rationalize their behavior (e.g., viewing the counseling relationship as complete and separate or by claiming that their connection transcends professional boundaries), as other therapists who become aware of a colleague's misconduct also may minimize their colleague's behavior or even blame the client (Alpert & Steinberg, 2017; Gabbard, 2017; Goren, 2017). We use the term "sexual or romantic misconduct" to denote the *sole* responsibility for sexual or romantic

interactions with clients lies *with the counselor.* Romantic or sexual interactions with clients are abusive, exploitative, and harmful; hence, these interactions are not a "relationship" but are actions taken by the counselor that directly violate professional boundaries, resulting in one of the most harmful forms of professional transgressions toward clients.

There is a lack of recent data on how often sexual misconduct occurs within therapeutic relationships, and an even further lack of data on romantic misconduct. Studies predating the early 2000s estimated that 7-12% of therapists engaged in sexual misconduct, which parallels more recent findings estimating rates of sexual misconduct by healthcare providers (Alpert & Steinberg, 2017; MacIntyre & Appel, 2020). Researchers have found that men who are mental health professionals are more likely to engage in sexual misconduct (MacIntyre & Appel, 2020), although therapists of any gender can transgress professional boundaries. Additionally, women clients are more likely to be victims of sexual misconduct by therapists, and trauma and sexual abuse backgrounds can increase vulnerability for clients to be exploited in therapy (Alpert & Steinberg, 2017). Although we do not have demographic data beyond the gender binary and abuse backgrounds that increases vulnerability to sexual misconduct from therapists in counseling, we can postulate that clients from marginalized backgrounds also may be at increased risk, given marginalized communities generally experience higher rates of sexual violence and exploitation due to systemic discrimination in the wider sociocultural context (CDC, 2024; RAINN, n.d.).

Although romantic or sexual interactions with current clients are viewed as clearly unethical and a form of professional misconduct, some related issues, such as romantic or sexual relationships with former clients, supervisees, or students, are less clear. Professional codes of ethics vary in their prohibitions on sexual or romantic interactions with former clients. AASECT's (2014) Code of Conduct is clear that certified members shall not engage in sexual behavior with former clients. The ACA Code of Ethics (2014) prohibits counselors from engaging in romantic or sexual relationships with clients, their partners, or their family members for a period of five years after terminating counseling services. APA's (2017) ethical principles specify a two-year interval post termination. However, clients may be vulnerable to the power differential inherent in the client-counselor relationship even after time has lapsed since the conclusion of therapy, particularly if the client participated in longer-term, intensive, or trauma-focused therapy. Wherein there is still potential to exploit or harm the client by entering into a romantic or sexual relationship with them or their family members, counselors should avoid these interactions and relationships (ACA, 2014). Defining what constitutes potentially exploitative or harmful behavior toward former clients is subjective and context-dependent, leading to a lack of clarity regarding the ethics of romantic or sexual relationships with former clients (Goren, 2017).

Moreover, there is an inherent power differential in supervisee-supervisor and student-counselor educator relationships; hence, supervisors and counselor educators are prohibited from romantic and sexual relationships with their current supervisees and students (ACA, 2024). The ethical codes (AASECT, 2020; ACA, 2014; APA, 2017) do not address what is appropriate or inappropriate ethical behavior in terms of sexual or romantic relationships with formers supervisees and students. In addition to relevant ethical codes, counselors should consult their

local jurisdiction's regulations and employer's policies when considering sexual relationships with former clients, current or former supervisees, and current or former students to ensure that they are not violating any legal statutes or institutional policies.

Though sexual or romantic interactions with clients are unethical, and a form of professional misconduct, sexual attractions or romantic feelings certainly may arise between clients and counselors, whether one-sided or mutual (Gabbard, 2017; Rodgers, 2011). Such attractions may be especially likely to develop when sexuality-related topics are discussed in session and may reflect natural human attraction processes and/or transference and countertransference (Goren, 2017). Many therapists feel ashamed when these romantic or sexual attractions and feelings arise toward their clients (Rodgers, 2011). However, romantic or sexual attractions toward clients can be a form of countertransference, reflecting counselors' own personal feelings or unresolved issues. When countertransference occurs, counselors should monitor their reactions carefully and examine the impact they have on the therapeutic relationship (Griffin-Shelley, 2009; Rodgers, 2011). Engaging in critical introspection, counselors should carefully monitor if and when they begin feeling an increased intimacy with clients that transcends professional boundaries. Counselors who experience romantic or sexual attractions toward clients should process their feelings with a clinical supervisor, colleagues, or their own therapist. Not only can these conversations provide valuable insights as to the reasons for counselors' attractions toward clients (Fisher, 2004; Rodgers, 2011) but also ensure that counselors take action to act ethically and prevent romantic or sexual misconduct. For a therapist to disclose their attractions to a client is more likely to cause harm than offer them any therapeutic benefits, and it can also expose the counselor to a potential slippery slope toward sexual or romantic misconduct (Fisher, 2004).

Clients who are attracted to their counselors may engage in various behaviors that push the limits of the professional boundaries of the client-counselor relationship (Steinberg et al., 2021). These behaviors may include enhancing their appearance for sessions, asking the counselor intimate questions about the details of their lives, making frequent unscheduled contacts with the counselor, or disclosing their attractions during sessions. Though there may be reasons other than romantic or sexual attraction that prompt clients to engage in these behaviors (e.g., becoming overly dependent on the therapeutic relationship as a source of aid and support), counselors should remain aware of changes in client behavior and directly address clients' actions that push the limits of professional boundaries, especially when these behaviors occur repeatedly or begin to escalate. Engaging in consultation or supervision is recommended, so counselors can ethically and appropriately reestablish the limits of the therapeutic relationship, or explore alternative options, such as referral to another counselor, with their clients. Clients experiencing romantic or sexual attraction toward counselors can prompt new avenues of exploration in therapy, stimulating growth opportunities and behavioral changes for clients when navigated effectively by counselors (Steinberg et al., 2021). Counselors also may encounter clients who were sexually or romantically exploited by previous therapists. These clients may require additional sensitivity and patience, recognizing how their trust and safety in the therapy room has been violated, in order to work through the negative impacts of those experiences (Bailey & Brown, 2021; Courtois et al., 2021).

Interdisciplinary Collaborations for Sexuality Counseling

Sexuality is a complex, interdisciplinary topic, requiring a variety of strategies to help clients with sexuality-related concerns (Hatzichristou et al., 2010; Goyal et al., 2022; Rosenbaum, 2011). Hence, we encourage counselors to think beyond the therapy room and consider how sexuality counseling can be enhanced through connections within the broader community and social context. Counselors working with clients on sexuality-related concerns should consider other community resources that may help clients make further progress toward their counseling goals. As described in the Contextualized Model of Sexuality, sexual issues can arise from physiological, psychological, contextual, relational, or developmental factors, or a combination of these. A first step in sexuality counseling is often referring clients to a medical provider for a physical examination to determine if physiological causes are contributing to clients' sexual concerns (Basson et al., 2010; Hatzichristou et al., 2010; Southern & Cade, 2011). As described more thoroughly in Chapter 2, medical interventions like medications or sexual aids may be useful for clients when there is a physiological basis for their concerns. Counselors working with clients who have sexual health concerns may collaborate with a diverse group of medical professionals, including cardiologists, endocrinologists, family physicians, general practitioners, gynecologists, neurologists, nurse practitioners, physician assistants, physical therapists, obstetricians, and urologists (Althof, 2010).

Beyond collaborations with medical professionals, counselors can assist their clients in accessing other potentially helpful resources, and work with professionals involved with these resources to promote clients' progress in counseling. For example, clients may benefit from information about sexual health related to specific concerns the client is facing. Therefore, counselors should familiarize themselves with credible, current, and accessible sexual health information (Pope et al., 2024a). Counselors also should be familiar with reputable community resources in their local areas, from health resources to support groups. Common health resources counselors may refer to are local health departments or Planned Parenthood locations, along with other agencies that offer HIV and sexually transmitted infection testing and free or reduced-cost contraception. Some clients may need assistance with finding legal advice or financial support, such as if they have experienced sexual exploitation or are seeking to leave an intimate relationship with an abusive partner. Other community-based programs that may be relevant for some clients include support programs for teenage parents, sex trafficking recovery organizations, intimate relationship education workshops, parenting education programs, and culture-specific organizations. Additionally, clients may benefit from connecting with supportive spaces, either online or in their local communities, for people of similar backgrounds or facing similar concerns. We provide resources throughout each chapter of this text, targeted to both client support and counselors' professional development.

Overview of the Remainder of this Book

The rest of the chapters in this book will delve deeper into the various sexuality-related areas and concerns that can impact clients. We begin by focusing on general strategies for clinical assessment and interventions in Chapter 2, followed by overarching areas that impact sexuality in regard to cultural and contextual influences in Chapter 3 and lifespan development in Chapter 4, respectively. The second section of this text dives in identities, relationships, and communities, reviewing gender identity, affectional and sexual orientation, diverse sexual expressions and communities, and intimate relationships in Chapters 5 through 8. The final third of the text examines specific areas of sexuality in context, including sexual trauma and healing, mental health, and physiological factors in Chapters 9 through 11. In Chapter 12, we conclude with how positive sexuality is a new paradigm for sexuality counseling, exploring how sex and sexuality are powerful channels for personal and relational growth. Throughout the book, our aim is to present a comprehensive, in-depth, practice-focused overview of sexuality counseling to equip counselors with the foundational information, assessment, and intervention strategies needed to effectively work with clients who are facing sexuality-related issues. We hope that readers will find this book to be a useful resource in helping clients navigate the complexity of their sexual selves and overall wellness.

Keystones

- Despite their professional training, counselors are not immune to the discomfort surrounding sexuality.
- Clients often seek counseling for concerns related to their sexuality, whether as their primary concern or as a secondary concern to more pressing issues.
- Sexuality is an essential topic for counselors need to be prepared to address in their work with clients.
- Based on the Contextualized Sexuality Model, positive sexuality is developed through attending to cultural and contextual influences, developmental influences, gender identity, affectional and sexual orientation, diverse sexual expressions and communities, intimate relationships, sexual trauma and healing, individual mental health, and physiological factors.
- Recently, the sexuality counseling field has shifted to a more comprehensive, systemic approach to understanding and treating sexual concerns.
- The main distinctions between sexuality counselors and sex therapists are the degrees of the intensity of the treatment and the complexity of the cases.
- Mental health professionals must understand their own level of preparedness to address sexuality-related issues in their work.

- Both cultural humility and cultural competency are foundational to counselors engaging in critical introspection and developing the ability to talk professionally and comfortably about sexuality.
- Counselors should strive to increase their comfort in talking about sexuality in a professional context.
- Sexuality counseling presents counselors with unique ethical considerations that reflect the sensitive and personal nature of the subject of sexuality.
- Sexuality is an interdisciplinary topic that can be addressed on many different levels. Counselors working with clients on sexuality-related concerns should consider other community resources and adjunct services that may help clients make further progress toward their treatment goals.

Additional Resources

- American Association of Sexuality Educators, Counselors, and Therapists (http://www.aasect.org/)
- American Association of Sexuality Educators, Counselors, and Therapists *Code of Conduct for AASECT Certified Members* (https://www.aasect.org/sites/default/files/documents/AASECT_Code-of-conduct-11.2020_4.20.23-edit_0.pdf)
- American Counseling Association *2014 Code of Ethics* (https://www.counseling.org/docs/default-source/ethics/2014-aca-code-of-ethics.pdf)
- Association for Counseling Sexology and Sexual Wellness (https://www.counselingsexology.com/)
- Association for Counseling Sexology and Sexual Wellness Exemplary Practices (https://www.counselingsexology.com/exemplary-practices)
- Sexuality Information and Education Council of the United States (https://siecus.org/)
- Society for the Advancement of Sexual Health (https://sash.net/)
- Society for Sex Therapy and Research (http://www.sstarnet.org/)
- Society for the Scientific Study of Sexuality (https://www.sexscience.org)
- World Association for Sexual Health (https://www.worldsexualhealth.net)

Chapter 2

General Assessment and Interventions in Sexuality Counseling

Learning Questions

2.1. What are general assessment strategies for sexuality counseling?

2.2. What are formal and informal strategies for assessing clients' sexual wellness across the different domains of the Contextualized Sexuality Model?

2.3. What are general guidelines for conducting sexuality counseling?

2.4. What approaches can be used to address sexuality-related concerns, including counseling interventions and medical treatments?

Introduction

Including the assessment of sexuality as part of the overall biopsychosocial assessment of clients' functioning during the intake interview is important for several reasons. First, sexuality is a central component of the human experience that impacts our overall psychological well-being (Pope et al., 2024; Zeglin et al., 2018). Sexual problems may impact and/or be impacted by clients' presenting issues, and thus, counselors may overlook major symptoms if they do not assess sexual concerns early in therapy. Secondly, as sexuality is a topic that is influenced by cultural norms, many of which serve to diminish and/or limit the experience of sexuality for individuals, clients may never have experienced open conversations about sexuality, may feel conflicted about sexuality, and may have internalized messages that impact their sexuality negatively and elicit anxiety, guilt, or shame. Many cultures do not actively promote a positive sexuality, which can create harmful consequences for individuals, including effects on their mental (e.g., low self-esteem, anxiety), interpersonal (e.g., sexual difficulties in intimate relationships), and physical

(e.g., not practicing safe sex) health. By inquiring about sexuality in the assessment process, counselors can create spaces to educate and support clients in developing a positive sexuality.

Finally, the culture of silence around sex leads many individuals to engage in risky sexual behaviors, such as a lack of barrier protection (e.g., condoms, diaphragms). The spread of sexually transmitted infections (STIs) and the occurrence of unintended pregnancies remain major public health concerns in the United States and beyond. Approximately 20% of Americans have an STI (Centers for Disease Control, 2024) and about 41% of pregnancies in the United States are unplanned (Rossen et al., 2023). In a time in which many medical professionals are finding themselves battling time constraints that do not allow for a holistic evaluation of their clients or patients (Barratt & Rand, 2009), counselors do have the ability to engage individuals in a thorough biopsychosocial evaluation. Even more important, counselors can build a therapeutic alliance so that clients feel comfortable opening up about matters as personal as sex. Thus, counselors are well-situated to evaluate individuals' sexual health and to promote safe sex practices through their counseling services. To ignore sexuality and not include it as part of the assessment process is to do a disservice not only to the individual clients that we are working with but also to the larger public, as open dialogues about sexuality are necessary to advance healthy sexual experiences.

We start this chapter with Case Illustrations 2.1, 2.2, and 2.3 for you to reflect on as you learn about the assessment of sexuality. As you read the rest of the chapter, consider what areas you would want to assess more in-depth with each of the following cases and what interview questions would be relevant to ask these clients.

Case Illustration 2.1 Case of Johnson and Anika

Johnson (age 30, he/him) and Anika (age 28, she/her) present to counseling with their main complaint being difficulties with sexual intimacy. Johnson is White and Anika is Asian American, who is a 2nd generation Indian immigrant. They have been married for 5 years and had their first child almost 1 year ago. Anika says that up until having their child, she was satisfied with their sex life as they were having sex almost every day. The frequency of their sexual activity has diminished to about twice a month, and Anika says she feels like Johnson no longer views her as a sexual being but just a "mother" as "he barely even touches me anymore." Johnson says that he knows sex is important to Anika and agrees his sexual desire has diminished since the birth of their son. Johnson says he has struggled with paternal postpartum depression and sought individual counseling, although he discontinued therapy a few months ago because he no longer felt it was helping.

Case Illustration 2.2 Case of Carson

The Wilsons are a Black, middle-class family who brought their only child, Carson (age 14, he/they) into counseling. Carson's parents, David (age 45, he/him) and Sarah (age 50, she/her) report that Carson came out as panromantic, asexual, and non-binary to them approximately eight months ago. They say that they were initially shocked but have been trying to learn more about how to support Carson and say they "love him no matter what because he is our child." David and Sarah are concerned because Carson has stopped talking to them like he used to about school and his friends, and they describe him as "sullen" and "quick-tempered" around the house over the past few months. During the intake session, Carson seems unwilling to talk to you in front of his parents, so you ask to meet with him individually for further assessment. As you meet with him alone, Carson starts to open up and begins to answer the intake questions from his perspective.

Case Illustration 2.3 Case of Winona

Winona (age 74, she/her) is a Cherokee woman who was referred by her oncologist to counseling. She was diagnosed with breast cancer approximately three years ago and went through chemotherapy, radiation, and a double mastectomy, which eliminated the cancer at that time. A few months ago, it was discovered that her cancer had returned in her lymph nodes during a physical checkup. Her oncologist is recommending more surgery to remove the affected lymph nodes, as well as follow-up chemotherapy and radiation, but Winona is currently refusing to have the treatment. Winona has been married for 42 years and has three children. Winona reports that she has missed several big events in her family, has been unable to care for her grandchildren, and has had difficulties being sexually intimate with her husband due to the side effects of the treatments over the past few years. She says that she is tired of having her quality of life diminished by the medical treatments and wants to put her health "in the Creator's hands" moving forward.

This chapter will begin by discussing skills for introducing sexuality-related topics into the intake interview with clients. Next, we will discuss how to assess how clients' presenting concerns may be impacting and/or impacted by their sexuality. The chapter will then outline informal and formal assessment tools related to a general assessment of clients' sexuality and sexual health and provides strategies for counselors to use informal assessment strategies to aid in defining clients' sexuality concerns, setting related goals, and informing treatment planning in counseling.

General Assessment Strategies

We begin with general recommendations on how to incorporate sexuality considerations into the initial assessment process with clients.

1. *Include questions related to sexuality as a part of the intake interview process you use with all clients.*

Clients typically will not initiate conversations about sexuality unless prompted to do so by their health care providers, including counselors, particularly if their presenting concern is not directly linked to sexuality. Of more concern is that counselors themselves may be reluctant to bring up the topic of sexuality during the initial session with clients (Harris & Hays, 2008; Dune, 2012; Hipp & Carlson, 2019). This hesitancy may occur because counselors are not used to talking about sex in their own lives, worry that they may embarrass or make their clients uncomfortable, and/or feel like they do not know what to ask or how to respond, and thus may appear incompetent (Risen, 2010; Wilson, 2019). Unless a client is presenting in a crisis or therapy is extremely time-limited, counselors should ask *every* client about sexuality-related questions and concerns, including intimate partners, older adults, adolescents, and the family members of younger children.

Immediately asking questions about sexuality may be abrupt and off-putting. However, gathering information about sex and sexuality can be integrated into the initial psychosocial assessment and be comfortably addressed as you build rapport with the client, even within the first session. Including general questions about sexuality in your initial paperwork and/or intake interview can help prompt clients to speak up about any sexuality-related concerns. Further, by including questions as part of the intake interview, counselors can offer a simple clarification if clients seem unsettled by the questions about sexuality, such as:

The intake includes questions about sexuality because it is an integral part of the human experience that contributes to our overall well-being as individuals. I would like for this to be a space where you can feel comfortable addressing any questions or concerns about sexuality you feel are relevant to your own reflection, growth, or counseling goals.

Addressing the relevance of your questions and inviting clients to speak openly about sexual topics can directly confront any awkwardness or embarrassment that clients may experience when sharing about their sexual health (Risen, 2010). In Table 2.1 we provide you with some sample interview questions for adult clients. Most of the questions below can be appropriately adapted for use with adolescents, and we also provide questions specific to children and youth in Chapter 4. We encourage you to add any questions that you think are relevant to your clients and/or counseling situation.

Table 2.1 ▪ *Sample Interview Questions for the General Assessment of Sexuality-Related Topics*

Number	Questions
1	How do you describe gender identity?
2	How do you describe sexual/affectional orientation?
3	Are you currently in an intimate relationship? How would you describe your relationship at this time?
4	How do you describe your desired relationship structure?
5	How was sex discussed and/or sexuality expressed in your family? What kinds of messages did you get from your parents/caregivers about sex?
6	What are experiences that stand out to you regarding your sexuality, including those from your childhood and/or teenage years? How do these experiences impact how you currently view your sexuality? Engage in sexual activity? Engage in intimate relationships?
7	What do you find pleasurable in terms of: Emotional intimacy? Physical intimacy? Sex, either alone or with others?
8	What are some of your sexual fantasies? How have you shared these fantasies with your (current or previous) partners? How have you explored acting on these fantasies, either by yourself or in relationships with others?
9	What are your feelings towards your body? Where did these messages about your body come from?
10	Are you sexually active? If so, how would you describe your sexual activity (e.g., how often, with whom, etc.)?
11	How are you engaging in healthy sexual practices, including: Use of barrier protection? Regular STI and HIV testing? Clear communication with all involved parties? Aftercare practices?
12	When was the last time you had a physical check-up from a healthcare provider? [Within the past year] What were the outcomes of your check-up? [If it has been over a year since their physical] How do you feel about scheduling an appointment for a check-up in the next few months? What are barriers to you seeking healthcare from medical providers?

(*Continued*)

Table 2.1 ▪ *Sample Interview Questions for the General Assessment of Sexuality-Related Topics (Continued)*

Number	Questions
13	Do you have any general medical conditions? If so, how have these medical conditions impacted your sexual wellness and/or interpersonal relationships? Have you talked with your healthcare provider(s) about how your medical conditions are impacting your sexual wellness and/or interpersonal relationships? If so, how did that conversation go with your healthcare provider?
14	Have you ever sought counseling previously or sought help for mental health concerns? If so, how have your mental health concerns impacted your sexual wellness and/or interpersonal relationships?
15	Do you have any sexuality-related concerns that you would like to discuss in counseling?
16	Have you talked with your healthcare provider(s) about your sexuality concerns? If so, how did that conversation go with your healthcare provider? If not, how do you feel about scheduling an appointment with your healthcare provider to discuss your concerns? How can I help prepare you for that conversation?

In addition to the above questions, Geist et al. (2019) offer the PATH approach as a clinical tool for assessing reproductive attitudes. PATH stands for Parenting/pregnancy attitudes, Timing, and How important it is to delay pregnancy. The PATH approach assesses for each of these areas using the following questions that we adapted for counselors: (a) What are your thoughts about having (more) children at some point?; (b) When do you think you would like to have children? (if the client wants to be a parent); (c) How do you plan to prevent pregnancy (until then)?, and (d) How have you discussed your intentions to prevent pregnancy and/or having children with your healthcare providers? Although the PATH tool was designed for healthcare providers to engage women in contraceptive counseling, it also may be useful for men and particularly for transgender and gender diverse (TGD) persons who plan to medically transition, to help them consider their fertility options (Bonnington et al., 2020). After asking these general questions, counselors can follow up with more specific questions based on clients' presenting concerns, as provided in each chapter throughout the rest of the text.

2. *Be matter-of-fact and objective as you discuss sexuality-related topics with clients, and utilize process skills and immediacy to address clients' discomfort in session.*

As sexuality remains a taboo topic and one that is not openly discussed or even acknowledged at times, do not be surprised if clients are uncomfortable discussing their sexuality, particularly in the initial few sessions (Risen, 2010). Some clients may have never had an in-depth or honest

discussion about sex or their sexuality with anyone in their lives before coming to counseling, so they may be unsure of how to talk about sex or how much to disclose in counseling. Clients who engage in diverse sexual relationships or practices, such as consensual nonmonogamy or kink, also may be hesitant to disclose their desired relationship structures or activities in counseling due to fear of judgment or discrimination (Sprott et al., 2021; Swindlehurst et al., 2024). As individuals tend to internalize messages that frame sex, their sexuality, and their body images in a negative light from their families, peers, culture, religion, and/or the media, the topic of sexuality may elicit feelings of anxiety, guilt, or shame for many clients. Anxiety, guilt, and shame tend to be emotions that people want to avoid experiencing, and thus, some clients may be reluctant to talk about sexuality-related topics to avoid facing those emotions.

Thus, it is important that you can remain matter-of-fact, objective, and comfortable as a counselor in discussing sexuality with clients so that your personal values and biases do not interfere with clients' openness to share about sexuality-related topics (Barratt & Rand, 2009; Emelianchick-Key et al., 2022). If you demonstrate your own discomfort, clients may interpret this as it not being okay to talk about sex or sexuality in counseling. At an extreme, showing uneasiness could be misconstrued as judgment of what clients are saying, which could cause harm by eliciting or reinforcing guilt and shame around their sexuality. Counselors, however, are subject to many of the same conflicting messages about sexuality that our clients receive, and thus, it is not uncommon for counselors-in-training to feel uncomfortable discussing sex in an open and straightforward manner (Harris & Hays, 2008; Hipp & Carlson, 2019). Counselors may avoid topics due to their inexperience with the sexual material being presented, difficulties imagining the experience their client is discussing, or because the material may elicit their own internal conflict due to past sexual experiences or personal values (Bungener et al., 2022; Emelianchick-Key et al., 2022; Risen, 2010; Wilson, 2019).

To practice asking questions related to sexuality similar to those you may use during an intake interview and to experience being asked questions about your sexuality in order to increase empathy for your clients, readers are invited to complete Exercise 2.1 in small groups. Readers who experience uneasiness during this activity may want to take other steps to practice talking about sexuality, such as initiating conversations about sex with a trusted partner, family member, or friend. Anyone who feels an intense amount of discomfort may want to seek individual counseling to increase their ability to discuss sex more openly with clients.

3. *Develop a sexuality vocabulary, recognizing that sometimes clients' words may be unfamiliar to you and that your words may be unknown to clients.*

Another area that counselors can struggle with when assessing sexuality with clients is the language to use to describe sexual experiences, typically due to discomfort with saying the words out loud or worries about offending or even harming their clients (Risen, 2010; Wilson, 2019).

Exercise 2.1 Sexuality Interview

Directions: In this exercise, we invite you to explore how you learned about sex as a child and adolescent. To increase your comfort in discussing topics related to sex with others, we encourage you to complete this activity with a peer, take turns being an interviewer and interviewee, although you may respond to these questions on your own as a form of self-reflection.

If completing this activity as an interview, spend approximately 30 minutes with each person being interviewed. As the interviewer, base your interview on the questions listed below, although you do not have to go through each question specifically. To increase the safety in this activity, **the interviewee should be reminded that they do not have to answer any question(s) that they do not want to answer.** Once the interviews are complete, process what it was like in each of the roles as interviewer and interviewee, reflecting on the following two questions:

1. What did you learn about yourself through this activity?
2. How does what you learned connect to your work with clients in counseling?

SUGGESTED QUESTIONS FOR SEXUALITY INTERVIEW:

1. What are your earliest memories of learning about sex? What emotions do you remember experiencing when you were first learning about sex?
2. What kind of communication did you have with your parents/caregivers about sex? What adults in your life did you feel comfortable talking about sex with while growing up?
3. What kinds of messages did you get from your parents/caregivers about sex?
4. As a child, what questions did you have about sex? To whom did you ask these questions? How were your questions answered?
5. What kinds of messages did you receive about gender (including gender roles and expression) from your family?
6. What kinds of messages did you get from your parents/caregivers about your body? How did these messages impact your experience of your body as you were growing up?
7. How did you talk about sex with your friends while growing up? What messages did you get about sex from your friends?
8. How did your peers influence your views about sex while growing up?
9. What messages about sex did you observe in the media as you were growing up? About bodies? How did these messages impact you as you were growing up?
10. Considering what you discussed in how you learned about sex growing up, how do these experiences still impact you today as an adult?

During the activity, you may modify these questions or add other related questions. Other topics to ask about may include messages and/or experiences with sexual play as a child, sexual education in schools, masturbation, contraception, and early sexual feelings and experiences. Asking about how others reacted to the disclosure of these experiences may also be relevant to understanding your own beliefs about sex and sexuality.

* Note: This activity was adapted from the Sexuality and Mental Health course that was taught by Dr. Peter Sherrard in the University of Florida Department of Counselor Education.

It is important that counselors develop an ease in saying words related to sex and sexuality, as well as skills for how to handle language discrepancies that will inevitably come up during session. Counselors need to get comfortable with sex-related terminology, as it is up to us to introduce the words into counseling so that clients feel allowed to use sexual language as well. Exercise 2.2 invites you to generate sexuality-related terms in a group setting and to practice saying the terms out loud in front of others.

At times, clients may seem uncomfortable with a term that a counselor uses during a session. If you notice clients' discomfort, perhaps they are appearing uneasy or are avoiding using the term themselves, you can bring that to the forefront by saying, "It seems that when I describe your concerns as 'erectile difficulties' that it is not quite fitting with your experience. Can you tell me how you would describe your concerns in your own words?" The language around sexuality is constantly evolving to reflect our sexual understanding, so clients may use terms that are foreign to us. People use many different words, including cultural slang, to describe sexual experiences, and it is not necessary for counselors to know every sexuality-related term in our vernacular. What is more important is for counselors to inquire about unfamiliar expressions with clients so that they understand what the client is presenting during sessions (Risen, 2010), which can be done by simply asking, "Can you tell me what the term [insert expression] means? It's not one I've heard before."

Exercise 2.2 Increasing Comfort With Sexuality-Related Language

Directions: In a small group, generate a list of at least 30 words related to sex, sexuality, or intercourse. Everyone in the group should add at least one term to the list and try not to censor the terms that you contribute. Once you have constructed a list of terms, consider the following questions:

1. Which terms are you familiar with?
2. Which terms are you not familiar with? If one of your group members is not familiar with a term that you proposed, try explaining what the term means to your group.
3. Which terms are you comfortable using when talking to others?
4. Which terms would you be uncomfortable hearing from another person?
5. Which terms would you be uncomfortable saying out loud?

Next, select three of the terms you identified in the last two questions above. In your small group or as pairs, practice saying each of the three words out loud at least five times. Try to stay aware of your thoughts, feelings, and behaviors while vocalizing the words to

another person, as well as being in tune with your experience in hearing others say the words they selected. Briefly process your experience:

1. What was it like for you the first time that you vocalized the terms that you selected?
2. What was it like for you by the last time that you stated the words?
3. What was it like listening to others verbalize the words they selected?

1. *Focus your assessment on clients' current sexual health and the holistic experience of sex, including satisfaction and pleasure.*

Rather than taking an unnecessary history of sexual behaviors that often is not extremely relevant to current sexual health behaviors (Barratt & Rand, 2009), counselors should stay focused on clients' recent sexual experiences and present sexuality-related concerns during their assessment. Additionally, counselors can utilize questions that normalize sexual satisfaction and pleasure, such as "What do you find pleasurable in regard to sex or physical touch, whether alone or with others?" Further, our experiences of sexuality are impacted by sociocultural and relational factors (Southern & Cade, 2011; Pope et al., 2024), so history-taking in regard to sexuality assessment should focus on the impact of contextual factors (e.g., family of origin messages, cultural values, and political contexts) instead of just obtaining specific information related to current or past sexual activities. For example, in Case 1 with Johnson and Anika, it may be useful for a counselor to inquire about their positive experiences with sex and physical intimacy prior to their baby being born, their beliefs and values toward parenting, and how their views of each other have changed since becoming parents, as it seems there may be some gendered messages that are contributing to their intimacy difficulties. However, it likely would be less pertinent to explore specific details about their sexual activity in other relationships unless it seems experiences from those previous relationships are impacting their current concerns. Thus, counselors should assess clients' sexual history as it is relevant to their existing concerns but be aware when a line of questioning does not seem significant to understanding clients' presenting issues.

Dimensions of Assessment in Sexuality Counseling

If clients identify any sexuality-related concerns during the general assessment process, counselors will want to follow up with more specific questions based on their presenting concerns. Counselors should use their clinical judgment to decide which areas require more in-depth assessment with clients. As discussed in Chapter 1, human sexuality is complex and shaped by multiple, interacting influences. Familiarity with assessment strategies for each of these influences is important for counselors to evaluate clients' functioning across the various levels of sexuality and to identify a starting point for interventions.

In each chapter throughout this text, we include a list of open-ended questions specific to the topic that can be used during the clinical interview. These questions are meant to serve as a starting point to guide the assessment process, and thus, counselors may need to add other questions to gather more specific information from their clients. Further, these questions are

meant to serve as guidelines, so the wording should be tailored to fit each counselor's personal style as well as the identities or needs of each client. In each of the following chapters, we also provide suggestions for formal assessment instruments that can be used when deeper insights are required or when a structured approach is beneficial for understanding a client's situation. These instruments can complement the open-ended questions, allowing counselors to triangulate data and ensure a more comprehensive evaluation. Before using any instruments, readers should consult the original sources listed in the directory for more information about administration of the assessments with clients, particularly their applicability to diverse populations. Some of the instruments listed may need to be purchased for clinical use, while others are publicly available for free administration. For a comprehensive resource on sexuality assessments, refer to the *Handbook of Sexuality-Related Measures,* 4th edition (Milhausen et al., 2020).

Assessment is integral to collaborative goal setting and effective treatment planning in counseling. Counseling as a profession emphasizes holism, wellness, and development over the lifespan, and as sexuality is an essential part of human well-being (Diamond & Huebner, 2012), counselors need to include sexuality as a component during the assessment phase with all clients.

General Guidelines for Sexuality Counseling

Counselors may draw from a wide range of theory- and practice-based approaches when working with clients to address sexuality concerns. In particular, counselors may adapt sex therapy interventions, presuming they work within the bounds of their competence and training. We begin this chapter with general recommendations for culturally responsive sexuality counseling practice. Then, we review a range of intervention approaches and models that can be used to address a variety of presenting concerns related to sexuality. Regardless of the treatment approach used, counselors can aim to create a supportive therapeutic environment for addressing the sensitive topics that can arise when discussing sexuality concerns. Toward that end, we offer the following eight general guidelines for sexuality counseling:

1. *Hold space for clients*.

   Sexuality counseling requires a supportive, cooperative context that is fostered by the counselor (Rosenbaum, 2009; Southern & Cade, 2011). *Holding space* is a powerful practice for promoting well-being and inclusion, involving compassionately centering someone else's needs and feelings rather than one's own. Holding space is a form of nonjudgmental presence in which the counselor actively listens to and validates clients' experiences, resists the urge to appraise or fix them, and comes alongside the client as they engage in self-exploration. The earliest sessions of sexuality counseling should focus on building rapport, and therefore, they may not involve the client discussing their sexual concerns in great detail. Further, sexuality is often deeply intertwined with personal identities and values. Because each client's perspectives and meaning systems are unique, it is important for counselors to explore and validate clients' sociocultural influences and meaning systems regarding their sexuality-related

experiences (Rosenbaum, 2009; Zeglin et al., 2018). As "the primary responsibility of counselors is to respect the dignity and promote the welfare of clients" (ACA, 2014, p. 4,), counselors should actively create environments where those who are often silenced feel heard, seen, and supported through holding space (van der Kwaak et al., 2010; Zeglin et al., 2018). Ultimately, holding space is about supporting clients' journeys toward healing and self-discovery while honoring their autonomy and individual pace.

2. *Incorporate sexuality as a part of holistic assessment and treatment planning.*

Sexuality counseling treatment plans should be grounded firmly in data collected through the counselor's clinical assessment of the client (Bartlik et al., 2005; Hatzichristou et al., 2010). Many clients are reluctant to seek treatment for sexual concerns, and in fact, many people with sexual problems don't seek any help at all (Stinson, 2009). Often, clients will feel too embarrassed to bring up topics related to sex or sexuality, may wait for a clinician to address the topic, or not be completely open about sexuality-related topics (Sadovsky et al., 2011; Blanchard & Faber, 2016). Hence, the assessment process should be comprehensive, inclusive of questions to explore sexuality and sexual wellness, and attentive to the interplay between biology, psychological influences, and relational and other sociocultural factors (Basson et al., 2010). Further, assessments should consider clients' intrapersonal strengths, interpersonal and social resources, and sources of sexual satisfaction and pleasure. When establishing a treatment plan and identifying counseling goals, it is important to ensure that these are consistent with the clients' priorities that emerge through the assessment process.

3. *Be adaptable with your treatment approach.*

Sexuality counseling requires flexibility with regards to identifying the best treatment format. At different points in treatment, clients may benefit from individual counseling (Althof, 2010), group counseling (Althof, 2010; Basson et al., 2010), family counseling, and/or intimate relationship counseling. Family counseling may be preferable with children and adolescents, as a means of eliciting parent/caregiver support to address sexuality-related concerns or improve familial communication about sex. Couples or relationship counseling is especially useful when sexual concerns are linked to intimate relationship problems, or when negative interaction cycles are interfering with physical intimacy (Johnson 2017; Johnson et al., 2018). With relationship and family counseling, who is included in sessions may vary over the course of counseling. For instance, a family counselor would not include younger siblings in a session in which an adolescent wants to talk to their parents about obtaining contraception before becoming sexually active with their partner. This is both due to the appropriateness of the topic for the younger siblings as well as to respect the privacy of the adolescent client. Therefore, counselors should continue assessment throughout counseling to determine the most appropriate treatment format, discuss

treatment format options with clients, and collaboratively determine the best format(s) to address the clients' presenting concerns.

4. *Refer clients to medical providers as appropriate*.

Sexuality is an inherently interdisciplinary issue, so counselors must think beyond solely psychotherapeutic approaches to address clients' sexuality concerns (Hatzichristou et al., 2010; Goyal et al., 2022; Rosenbaum, 2011). Sexual problems may stem from physiological causes (e.g., anatomic or biochemical problems), psychological and relational causes, or a combination of both (Hatzichristou et al., 2010). Therefore, a physical examination should always be a precursor to clinical assessment and treatment when physiological causes are suspected (Basson et al., 2010; Hatzichristou et al., 2010; Southern & Cade, 2011). Some physiological issues to rule out as potential causes or contributors to sexual problems include hormone levels, medical conditions, medication side effects, substance use, and age-related changes (Southern & Cade, 2011).

As discussed in Chapter 5, TGD clients may want to pursue medical transitioning. Further, both TGD and LGBQA+ people may encounter discrimination or biases from healthcare providers (Macapagal et al., 2016). An important aspect of culturally responsive care with these communities is identifying affirming medical providers as appropriate referral sources. Likewise, there has been a growing push for medical professionals to be more inclusive of psychotherapeutic approaches (Rosenbaum, 2011; Goyal et al., 2022). In practice, the integration of these approaches can be difficult, so further efforts are needed to ensure that interdisciplinary models to address sexuality concerns are available to meet clients' needs (Rosenbaum, 2011). However, we urge counselors to make efforts to build collaborative relationships with medical professionals in order to provide comprehensive, coordinated treatment for their clients.

5. *Be comprehensive in your approach.*

Sexuality is a complex issue that clients experience in many areas of their lives. Clients may enter counseling with a somewhat narrow view of their sexuality concerns, such as focusing on a specific physiological function such as not being able to orgasm. Counselors can help clients explore new dimensions of sexuality so that they can come to view sexuality as a more comprehensive aspect of their lives (Juergens et al., 2009). Sexuality counseling should include a consideration of multiple dimensions of client well-being and address a comprehensive set of topics that are relevant to clients' presenting concerns. Some of the topics that may be addressed depending on clients' unique circumstances are as follows: areas of sexual distress and sexual satisfaction/pleasure, body image, cultural values, developmental history, emotional components of sexuality, family-of-origin dynamics, gender influences, intimacy issues, masturbation, mental health concerns that impact sexuality, physical health and wellness, relational functioning, relationship history, sexual functioning, spiritual beliefs, and trauma history (Southern & Cade, 2011; Pope et al., 2024a; Zeglin et al.,

2018). Attention also should be given to clients' readiness to make changes (Southern & Cade, 2011) and may incorporate motivational interviewing techniques. This extensive list of topics underscores the importance of counselors taking a broad view to understanding and addressing clients' sexuality-related concerns.

6. *Address sexual satisfaction and pleasure, not just problems.*

Clients may present for sexuality counseling with a focus on problems. They may want those problems to be resolved, but counselors can go beyond merely aiming for problem resolution to helping clients achieve greater sexual satisfaction and pleasure in their lives and relationships. As defined in Chapter 1, sexual wellness is not just the absence of problems, but a holistic measure of how individuals feel toward their sexuality and sexual relationships (Association of Counseling Sexology and Sexual Wellness, 2019). Historically, sexuality has been addressed in counseling from a medical model, with a focus on eliminating sexual dysfunctions and "abnormal" sexual behavior (Cruz et al., 2017; Zeglin et al., 2019). The medical model reinforces a sex-negative perspective, framing sexuality and sexual activity as potentially problematic or harmful (Cruz et al., 2017).

A sex-positive approach to assessment in sexuality counseling includes highlighting the pleasurable aspects of sex, inviting exploration of their desired ways of being and relationship structures, and fostering open communication about clients' values and needs. This shift in focus encourages clients to view their sexuality as a natural and positive part of their lives. As seen in Table 2.1, most of our sample interview questions are framed from a sex-positive perspective; for instance, asking questions that assume clients are engaging in healthy sexual practices rather than starting from a deficit approach (i.e., what clients are not doing). For clients who present with concerns related to their sexuality, counselors should assess for areas where clients experience sexual pleasure or satisfaction to identify exceptions to the problem. Even when clients do not report sexual problems, counselors should not ignore sexuality as part of the assessment process, as sex and sexuality may be a source of strength and fulfilment for clients that can aid in addressing their presenting concerns (e.g., a client presenting with generalized anxiety engages in BDSM as a form of meditation).

7. *Address sexuality within a developmental and sociocultural context.*

A sex-positive approach to assessment also situates sexuality within the context of clients' development over the lifespan and environments (Cruz et al., 2017; Zeglin et al., 2019). Sexuality is not static over time. Individual and relational development as well as sociocultural factors impact how people experience sexuality and intimacy. Although counseling as a profession centers developmental frameworks in understanding individuals' mental health in the context of their life stages and experiences, sexuality is still primarily covered in counselor education from a medical model. For instance, the role of sexuality is often absent from the predominant models of wellness used in the counseling field (Zeglin et al., 2019). Further, a recent review of

sexuality courses counseling programs found more use of medical model language (e.g., sexual dysfunction) than sex-positive frameworks in the course descriptions (Pope et al., 2024b).

Changes in sexual functioning and sexual satisfaction naturally fluctuate over time (Mintz et al., 2012). Additionally, gender identity, affectional orientation, and sexual orientation are fluid and multifaceted rather than fixed qualities throughout the lifespan (Singh, 2018; Ventriglio et al., 2021). Counselors can help clients view changes and fluctuations as opportunities for growth and exploration, rather than become discouraged by them. It is useful to maintain a focus on strengths at any developmental phase, so counselors also should address positive emotions, resiliency factors, and sources of relational and sexual intimacy as resources that can support and promote client growth.

Although sexuality is a highly personal matter for many people, sociocultural attitudes and values have a significant impact on individuals' sexual desires, relationships, and practices (Burnes et al., 2017; Cruz et al., 2017). As discussed in Chapter 1, sex is a taboo topic in many cultures, including in the United States. When sociocultural attitudes toward sex are negative, then it is more likely individuals will internalize these sex-negative messages and develop associated feelings of discomfort, shame, or fear related to their sexualities or bodies (Burnes et al., 2017; Cruz et al., 2017). Hence, assessing for how sociocultural factors influence clients' sexualities is an essential part of a holistic assessment process (Zielinski, 2013).

Although it is not uncommon for sociocultural factors, including familial values, religious/spiritual beliefs, or media messages, to negatively impact clients' views of their sexuality and/or body image, others may have experienced positive messages that shaped their sexuality in an affirming or helpful manner. For example, a client's family who emphasized movement and a balanced diet as markers of physical health, rather than body size, contributed to a positive relationship with their body as an adult throughout changes to their body shape and weight fluctuations. Hence, counselors should frame interview questions, as we have done in Table 2.1, that do not assume whether sociocultural factors have impacted clients positively or negatively.

8. *Apply the common factors framework.*

The sizeable contribution of client and extra-therapeutic factors provides a reminder to counselors that much of clients' progress toward their treatment goals stems from clients' actions and experiences that occur outside of counseling sessions (Donahey & Miller, 2000; Leibert, 2011). Client factors refer to how clients present to counseling, including motivation to change, personality characteristics, and symptom chronicity and severity. Extra-therapeutic factors include clients' sociocultural environments, relationships, and other life changes or events (Leibert & Dunne-Bryant, 2014). Two specific areas that impact client outcomes are clients' self-determination (e.g., motivation and autonomy) and social support (Leibert & Dunne-Bryant, 2014). Using motivational interviewing or other interventions that target intrinsic desire to take

action for personal growth (versus attending counseling to avoid consequences) may help clients increase their internal motivation to achieve counseling goals. Additionally, counselors can support their clients in addressing barriers, accessing resources, and building support systems to promote progress between sessions.

Likewise, the therapeutic relationship is an important consideration for sexuality counselors. Especially given the sensitive nature of the issues discussed, counselors must be especially mindful of building a strong alliance with their clients to address their clients' sexuality-related concerns. Validating clients' experiences and holding space for them to explore their sexuality are key components of developing a bond with clients. Additionally, collaborating on goal-setting and the treatment process also can strengthen the therapeutic alliance, as clients are more likely to engage in the work when they agree to the goals and understand the methods the counselors will use to meet those goals (Leibert & Dunne-Bryant, 2014).

Regarding expectancy effects, counselors should seek to understand their clients' beliefs about what they hope and expect to receive through the sexuality counseling experience. Clients who begin counseling with negative expectations or limited hope that they will change may again benefit from motivational interventions, as well as a more intentional focus on small, achievable goals in working toward longer-term change. Highlighting the impact of expectancy effects on sexual functioning, placebo response rates are high in clinical trials with women experiencing low sexual interest/arousal, with 40% of women reporting a significant improvement in symptoms after receiving the placebo intervention (versus the treatment intervention of taking medication) (Bradford, 2013). Hence, hopefulness and anticipating improvement has an impact on outcomes with both mental health and medical interventions (Leibert & Dunne-Bryant, 2014).

Although specific therapeutic modalities contribute a relatively small percentage to the change that clients experience through counseling, theoretical and evidence-based approaches are still a necessary part of counseling to provide a specific structure and lens for conceptualizing clients' cases and guiding interventions. Hence, although sexuality counseling is enhanced to the greatest extent by focusing on helping clients change outside of sessions and strengthening the client-counselor relationship, specific treatment modalities are important to understand and utilize in connection with clients' treatment goals (Donahey & Miller, 2000; Leibert, 2011; Leibert & Dunne-Bryant, 2014). Given the broad range of approaches to sexuality counseling, counselors have a variety of resources at their disposal to be able to incorporate different theoretical approaches and techniques to meet each client's unique needs. There is a growing body of research that supports the value of sexuality counseling, especially to address the social and emotional context of sexual problems. To address a growing demand for evidence that the interventions they use work, sexuality counselors should use evidence-supported interventions when available and track treatment outcomes with the clients they serve.

The common factors framework is not a call to abandon theory altogether. Rather, it underscores the importance of delivering evidence-based interventions within a context that

fosters positive growth by mobilizing the power of the other powerful influences on client change. In particular, counselors can help clients create a supportive environment for change (e.g., by connecting to other resources in the community and fostering additional social support), develop positive expectations about their ability to change, and feel valued and supported within a strong relationship with the counselor. It is in that spirit that we move to the next section, which reviews a range of treatment approaches for addressing sexuality concerns.

Review of Treatment Approaches to Sexuality Counseling

Modern sexuality counseling approaches tend to be highly integrative (Southern & Cade, 2011). In today's postmodern world, sexuality counseling and sex therapy have adopted interventions from a variety of other approaches to psychotherapy (Binik & Meana, 2009). Rather than adhering rigidly to one specific treatment approach, many sexuality counselors prefer to draw upon numerous theory-based intervention strategies. This is good news for clients, who benefit when they are able to choose from a range of potential treatment options.

Further, the increase of telemental health services since the COVID-19 pandemic has also led to growth in delivering sex therapy or sexuality counseling via telehealth. Researchers have found that telehealth is an effective modality to improve sexual wellness in multiple areas, including enhancing self-efficacy and sexual health behaviors of adolescents (Saragih et al., 2024), reducing marginalization stress for LGBTQ+ youth (Pachankis et al., 2023), and couples and relationship therapy (Bradford et al., 2024). Other scholars and clinicians have put forward models of telemental health treatment for survivors of child sexual abuse (Azzopardi et al., 2022), adults experiencing human and sex trafficking (Vujanovic et al., 2022), and high-conflict couples (Hoss et al., 2023). Although the research on telemental health outcomes compared to in-person therapy is still in the early stages, preliminary findings show its usefulness in sexuality counseling, particularly as telemental health increases access to services for individuals who may face geographical, financial, or mobility may be barriers to therapy.

In this section, we aim to familiarize readers with the range of sexuality counseling approaches and interventions that are available. First, we discuss the use of postmodern and critical theories to set the stage for culturally responsive counseling. Second, we review cognitive-behavioral approaches interventions. Third, we discuss systemic approaches to sexuality counseling. Fourth, we provide information about telehealth as a treatment option that increases accessibility for clients seeking support. Lastly, we review the importance of collaboration with medical providers in the provision of sexuality counseling.

Critical Theories

Critical theories highlight the experiences of communities whose identities are often pushed to the margins and consider the contextual factors, including systems of power and oppression, that shape how marginalized individuals make meaning of their sexualities. In this section, we briefly

review the predominant critical theories that have been adapted to therapeutic practice, and how each theory impacts conceptualization of sexuality in diverse populations. We encourage readers who want to learn more about the critical theories to consult the references at the end of this chapter. We conclude with commonalities of the critical theories and suggested interventions for sexuality counseling, geared towards transforming societal discrimination and systemic inequities that render invisible or invalidate sexualities that do not coincide with the dominant sociocultural norms.

Critical Race Theory

Critical Race Theory (CRT) emerged in the 1970s, developed by legal scholars and activists in response to the erosion of Civil Rights Movement gains in the 1960s (Delgado & Stefancic, 1993). CRT expands the understanding of racism beyond intentional acts of prejudice, acknowledging that racism is embedded in social systems, laws, and policies. It recognizes that racism has deep roots in white supremacy and colonialism, and that its impacts persist in contemporary society (Salter & Haugen, 2017). This perspective challenges the notion that racism only occurs in overt or individual forms, recognizing its pervasive and institutionalized nature. One of the key tenets of CRT is the concept of white privilege, in which white identity is often regarded as a valuable asset, something to be protected and maintained, contributing to ongoing racial disparities (Salter & Haugen, 2017). This privilege, however, can obscure the lived realities of people of color whose experiences are shaped by systemic racism and oppression. Hence, a central aspect of CRT is the elevation of *counternarratives*, the personal and collective stories of BIPOC communities. These narratives serve both as a form of resistance and a way to illuminate the persistent presence of racism and its effects on everyday life (Brown & Jackson, 2013; McCoy, 2018). In applying CRT to sexuality counseling, it is essential for counselors to actively listen to, respect, and validate the experiences of BIPOC clients, considering how racialized and sexualized experiences impact their lives. Counselors should do their own research and learning about how the history of white supremacy and colonialism impacts BIPOC peoples' lived experiences, ways of being, and sexualities. Additionally, CRT calls for counselors to engage in sociopolitical action by challenging practices that sustain racial discrimination and creating inclusive spaces for BIPOC communities.

Critical Disability Theory (DisCrit)

Originating in the 1990s, DisCrit integrated the theoretical foundations of critical race theory with disability studies to examine how race and disability form perceptions of normativity, or what constitutes a "normal" body and mind (i.e., White, middle class, and people without disabilities) (Annamma et al., 2018). For example, recent discourse in the disability literature reviews the use of person-first (e.g., people with disabilities or people without disabilities) versus identity first (e.g., disabled people or nondisabled people) language, critiquing how person-first language tends to be only used for people with disabilities and not people without, furthering the stigma associated with disabilities (Andrews et al., 2019; Gernsbacher, 2017). There is not a consensus within disability communities over the use of person- or identity-first language, with

some people feeling person-first language is more respectful by not equating a person with their disability, and others encouraging identity-first language as an expression of identity and pride, such as in autistic and Deaf communities (Andrews et al., 2019). We choose to use person-first language throughout this text, for both people with and without disabilities; however, counselors should always defer to the language their clients prefer when describing their disabilities.

Additionally, DisCrit is a call to action to dismantle policies and practices that reinforce marginalization of individuals with disabilities, particularly for people of color, and to create more inclusive and equitable spaces that support disabled communities (Annamma et al., 2013). In terms of application to sexuality, DisCrit honors the agency of people with disabilities, counteracting portrayals of people with disabilities as uninterested in sex or incapable of sexual relationships and pleasure (Rosas, 2022). Considering how multiple identities, such as race, gender, and socioeconomic status, interact with disability to shape individuals' sexual experiences and access to resources, DisCrit advocates for a broader understanding of what constitutes healthy sexual expression. DisCrit promotes the representation of individuals with disabilities in conversations about their sexual rights, relationships, and expression, particularly in the shaping of policies and laws that impact their autonomy and opportunities to engage in sexual activity or relationships (Rosas, 2022).

Critical Gerontology Theory

Critical gerontology theory was developed in the late 1970s and early 1980s to challenge the dichotomy between older adults as frail and an impending burden on society versus older adults as independent, physically active individuals who are in the "prime" of their life (Doheny & Jones, 2021; Flores-Sandoval & Kinsella, 2020). Critical gerontology theory critiques early medical models of aging that focus primarily on disease and disability, introducing a more nuanced conceptualizing of aging that values individuals' unique lived experiences, inclusive of the mind, body, and spirit, rather than categorizing them into a uniform group of older adults. This theory also counters normative concepts of successful generativity (Erikson, 1963) as connected to reproduction, in which the ideal way to guide the next generation is through having one's own children and grandchildren, recognizing the diverse ways that older adults create lasting impacts on their communities through cultural heritage, spiritual connections, activism, or creative expressions (Chazan, 2020). Similar to DisCrit, critical gerontology confronts ageist stereotypes that portray older adults as sexually incapable or disinterested in sexual activity, advocating for a more nuanced understanding of their sexual desires. Further, critical gerontology highlights the importance of providing accessible sexual health education and services tailored to the needs of older adults, addressing barriers that may impeded their sexual wellness. Additionally, the theory calls for policies that recognize and protect the sexual rights of older adults, promoting inclusivity and addressing issues such as consent, autonomy, and sexual health.

Feminist Theory

Feminist theory seeks to challenge how power and privilege is upheld through cultural paradigms surrounding gender and sex (Sommers-Flanagan, 2015). Although initially focused on women's

liberation, recent waves of feminist movements embrace intersectionality and how race, class, disability, and other identities play a significant role in shaping individuals' experiences of power, privilege, and oppression (hooks, 2015). Feminist philosophy has greatly influenced the sex positivity movement by deconstructing patriarchal concepts of sexuality, embracing sexual pleasure, sexual fluidity, bodily autonomy, and sexual exploration as components of creating more equitable and inclusive systems of sexuality (Mosher, 2017). In counseling, feminist therapy validates clients' experiences of marginalization and encourages clients to recognize how social forces contribute to a loss of power and autonomy in their lives. Feminist approaches foster a collaborative and equitable dynamic in the counseling process and support clients toward challenging harmful societal norms and making choices that align with their authentic selves.

Intersectionality Theory

Intersectionality theory was initially developed by CRT scholar Kimberlé Crenshaw, explaining how Black women experience both racial and gender discrimination in the workplace. Intersectionality has since evolved to a broader theoretical framework that examines how individuals with multiple marginalized identities experience compounded forms of subjugation. As Crenshaw (2010) articulates, the more marginalized identities an individual holds, the greater the degree of oppression they face. Rather than focusing on a singular identity, intersectionality addresses the complexities of identity and systemic inequality in more nuanced ways. Holding multiple marginalized identities can compound and intensify vulnerability, susceptibility to structural violence, and erasure of specific needs and experiences from public discourse (French et al., 2020). In the context of sexuality counseling, an intersectional approach is essential for advancing social justice and promoting equity in sexual wellness. An intersectional lens helps ensure that all clients are seen and heard in the fullness of their identities, and that their specific vulnerabilities and needs are addressed in the therapeutic process.

Liberation Psychology

Liberation psychology grew out of psychology and social activism in Latin America. Developed in the 1990s by Ignacio Martín-Baró, liberation psychology calls for counselors to reorient toward the perspectives of marginalized communities, lifting up their cultural traditions and historical memories to both improve their own lived experiences and to transform oppressive systems (Chávez et al., 2016). Key tenets of liberation psychology include *realism-crítico,* moving toward potential solutions rather than solely focusing on problems, and *concientización,* collaborating with clients to raise their awareness about how the historical and sociocultural context impacts their concerns, as well as their personal and collective strengths and power (Chávez et al., 2016; Martín-Baró, 1994; Singh et al., 2020, 2023). One strategy to engage in consciousness-raising with clients is to support them in exploring their cultural history as relevant to their personal identities, accessing books, documentaries, or other source materials that showcases the collective wisdom, power, and activism of their communities. Seeing how similar people fostered hope, joy, love, and creativity even in the face of oppressive systems, and identifying the actions they took that led to change in discriminatory practices, policies, or sociocultural attitudes, can help clients

identify strengths and strategies for their own healing (French et al., 2020). In terms of sexuality counseling, counselors can apply liberation psychology to help clients explore how sociocultural and historical norms impact their sexual identities, expression, and wellness, while highlighting their capacity for self-determination, sexual emancipation, and community restoration.

Relational-Cultural Theory

Relational-Cultural Theory (RCT), often considered a contemporary feminist perspective, emphasizes that people grow through and toward relationships throughout their lives (Jordan, 2000, 2017). Central to RCT is the recognition of human connection as a basic survival need, with mutual empathy and mutual empowerment seen as essential components of healthy, growth-promoting relationships. Another critical tenet of RCT is the belief that isolation is not only a primary source of suffering but also a means to maintain oppression (Jordan, 2017), which is particularly relevant when considering issues of sexuality. According to RCT, clients' concerns result from chronic disconnection, forced isolation, and structural disempowerment. In the context of counseling, RCT encourages real engagement and therapeutic authenticity to foster mutual empathy between the counselor and client, with the goals of healing disconnection, creating corrective relational experiences to challenge controlling thoughts and images, and increasing clients' consciousness related to power and oppression (Jordan, 2017). RCT can be applied to sexuality counseling through exploring how clients' connection and disconnection in relationships influence their sexual self-concept, desires, and behaviors. Further, RCT can facilitate healing by helping clients rebuild trust in themselves and in others through corrective relational experiences. Counselors can guide clients toward healthier, more supportive sexual relationships where mutual respect, empathy, and shared vulnerability are present. Finally, counselors can use RCT to address issues of power imbalances in clients' relationships, whether due to race, gender, class, or other identities and societal expectations, towards fostering empowerment and equality in sexual relationships.

Queer Theory

Queer theory is an interdisciplinary approach that emerged in the early 1990s, influenced by feminism and gay and lesbian studies. Queer theory is somewhat of a misnomer, as it is primarily "a collection of themes, concepts, and purposes relating to 'decentralized positionality,' hierarchy, statuses in social processes, relating to identity categories" (Goodrich et al., 2016, p. 619) rather than a model or framework. Queer theory fundamentally critiques conventional ideas about sexuality, gender, and essentialist identities by investigating how truth, language, and power function to uphold social control. Two additional key concepts are that power is relational and fluid (e.g., "power with" rather than absolute and static such as "power over), and that gender is performative, meaning individuals enact behaviors to align with their culture's gender expectations (Butler & Byrne, 2008). In relation to sexuality, queer theory challenges both the gender binary of male-female and the heterosexual-homosexual binary, arguing that these categories are socially constructed and limit the complexity and fluidity of gender, affectional, and sexual identities. By challenging these assumptions, clients develop ways

of being that are both empowering and healing (Rowland & Cornell, 2021). Additionally, queer theory calls for action to create inclusive spaces and disrupt dominant systems of oppression, including heteronormativity, patriarchy, and cisnormativity, which regulate and marginalize non-conforming identities. Ultimately, queer theory invites a reimagining of identity not as fixed or predetermined but as dynamic, fluid, and open to continual transformation.

Commonalities and Suggested Interventions

As you reviewed the critical theories presented in this chapter, you likely noticed the overlap in their foundational principles. Firstly, critical theories call for counselors to do their own internal work, building awareness of their own privilege and marginalization and how their identities, values, and biases impact how they show up in the room with clients. Counselors are active, subjective, and engaged participants in the therapeutic process, not just facilitators but co-creators of clients' self-knowledge, experiences, and responses during therapy (Butler & Byrne, 2008). Hence, critical theories position clients as the experts on their own lives, placing particular value on the historical and ancestral wisdom of individuals from marginalized backgrounds. Critical theories are useful in sexuality counseling to build a collaborative therapeutic relationship, balancing power dynamics between counselors and clients. These approaches honor the unique insights, intrinsic strengths, and lived experiences that clients bring to therapy, recognizing how clients are shaped by both personal and collective histories of resilience and resistance (French et al., 2020). Critical theories also emphasize holding space for clients to explore how they want to live authentically, honoring their freedom to embrace fluidity, flexibility, and the evolving nature of their identities and desires. Critical theories can be synthesized with a variety of therapeutic approaches to address sexual wellness, including person-centered, experiential engagement, constructivist theories (e.g., narrative, solution-focused), mindfulness, creative and artistic interventions, and community-based healing practices.

Critical theories also emphasize social justice and systemic action toward transforming systems of oppression. Rather than resiliency in the face of oppression being the end goal, critical theories call counselors to envision a world in which resiliency is not necessary through the envisioning and creation of more just and equitable systems (French et al., 2020; Singh et al., 2023). This involves actively resisting and dismantling the structural forces that perpetuate inequality and harm, such as racism, sexism, heterosexism, ableism, and classism. For marginalized populations, these intersecting systems of oppression often manifest in discrimination, violence, and the denigration of diverse sexual identities, expressions, and practices. Counselors are encouraged to work not only on an individual level with clients but also to engage in advocacy, policy change, and community mobilization efforts that address the root causes of social and systemic barriers to clients' well-being. In the context of sexual wellness, this includes supporting access to sexual and reproductive health resources, promoting inclusive and sex-positive sexual education, preventing sexual abuse and violence, and developing policies that support individuals' bodily autonomy. In this way, the focus shifts from simply surviving oppressive systems to actively working toward their transformation, underscoring the World Health Organization's (2024) human-rights based approach to sexuality. by fostering

environments where all individuals can achieve sexual well-being and pleasure without having to endure continual resistance to systemic oppression.

Trauma-Informed Approaches

Trauma can have a significant impact on people's sexuality and sexual experiences. Beyond overt sexuality-related trauma, such as sexual abuse, assault, or violence, other traumatic events also impact our physiological sensations, body image, ability to connect with others, and feelings of safety, all which influence one's sexuality (Covington, 2022; Zoldbrod, 2015). Developmental trauma, or chronic exposure to emotional, psychological, or physical abuse or neglect in childhood, has lasting neurobiological and interpersonal effects that can contribute to sexual challenges (Covington, 2022). Additionally, *marginalization stress*, the cumulative effects of oppression and lack of access to resources because of individuals' identities, is a form of traumatic invalidation (Cardona et al., 2022). Marginalization stress can contribute to trauma-based symptoms in clients, such as burnout, exhaustion, emotional dysregulation, avoidance-based coping, weakened immune system, or other mental and physical health issues (Caceres et al., 2020; Dawson et al., 2023; Hajek et al., 2023; Lopes et al., 2022). The vagus nerve is connected to the body's response to stress in regulating the autonomic nervous system and runs from the brain stem to the pelvic region. Trauma disrupts the functioning of the vagus nerve, impeding relaxation and digestive functioning, contributing to multiple physiological challenges that impact sexual functioning including genito-pelvic pain, irritable bowel syndrome, urinary incontinence, constipation, and overall pelvic floor health (Bonaz et al., 2017; Karsten et al., 2020; Krassioukov & Elliott, 2017).

Hence, a trauma-informed approach to sexuality counseling is essential to address the emotional, interpersonal, and physiological impacts of trauma on clients' sexual functioning. Clients with trauma histories may benefit from trauma-focused counseling, either alongside or prior to engaging in sexual counseling. Empirically supported models for trauma treatment include eye movement desensitization and reprocessing (EMDR), somatic experiencing, and several cognitive behavioral therapies, including cognitive processing therapy (CPT), trauma-focused cognitive behavioral therapy (TF-CBT), prolonged exposure therapy (PE), and dialectical behavior therapy (DBT), as well as mindfulness-based stress reduction (MBSR). EMDR and CPT have demonstrated effectiveness in treating sexual trauma, with more recent approaches integrating somatic and mind-body healing practices such as movement, breathwork, and yoga (Nixon, 2024). Counselors utilizing trauma-focused interventions need additional training and supervision to support the use of these treatments effectively. We also recommend any counselor engaging in extensive trauma-based work with clients to continue supervision and utilize consultation as source of support and burnout prevention. We review treatment strategies specific to sexual trauma and healing in Chapter 9.

Cognitive-Behavioral Interventions

Cognitive-behavioral approaches, including cognitive behavioral therapy (CBT), acceptance and commitment therapy (ACT), and mindfulness-based interventions are used widely in sexuality

counseling to treat a variety of presenting concerns. As with many of the mental health disorders in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5-TR), CBT has been utilized as the primary form of treatment for sexual disorders, alongside pharmaceutical interventions (Emanu et al., 2018; Flaherty et al., 2024; Matthews, 2020; ter Kuile et al., 2010). For instance, CBT has been adapted to reduce marginalization stress and enhance resiliency for clients of diverse affectional and sexual orientations and gender identities (Carvalho et al., 2022; Harkness et al., 2024).

The main elements of CBT include providing psychoeducation, cognitive interventions, mindfulness-based interventions, skills-focused interventions, and the use of homework between sessions. In this section, we discuss how counselors can apply each of these elements of CBT to sexuality counseling, as tied to the research evidence supporting this approach.

Psychoeducation

Psychoeducation is a critical component of treatment for sexuality-related issues (Althof, 2010; Hatzichristou et al., 2010; Tiefer, 2001). Educational information can benefit clients and their partners (Hatzichristou et al., 2010), especially in the early treatment phases (Basson et al., 2010). Many clients enter counseling possessing limited information and/or misinformation regarding sexual functioning, often as a result of minimal sex education at home or school. As such, many clients benefit from learning accurate information and developing new skills to enhance their sexual functioning. As Hatzichristou et al. (2010, p. 344) said, "Each patient has the right to be fully informed concerning his or her sexual health status, as well as the evidence-based treatment options that are available, in order to participate actively in the decision-making process."

Topics that clients may seek information about include "What is normal when it comes to sexual development?" and "How do disabilities, health conditions, or medications impact my sexual functioning?" (Juergens et al., 2009). Counselors should be prepared to provide psychoeducational information to clients about these and other topics, including the following: sexual anatomy and physiology, healthy sexual behaviors, intimacy and interpersonal relationships, and sexual exploitation and abuse (Basson et al., 2010; Juergens et al., 2009; Pope et al., 2024a). Counselors can deliver educational information through verbal instruction, assigned readings, video or audio content, illustrations, and anatomical models (Althof, 2010). When counselors reach the limits of their own knowledge, they can direct clients to other reputable resources for more information (Juergens et al., 2009). Counselors should ensure any psychoeducational materials shared with clients are from accurate and medically reputable sources, as well as considering how materials are inclusive and applicable to diverse populations (Pope et al., 2024a).

Cognitive Interventions

Cognitive interventions can be used to treat a variety of areas that impact sexual functioning, including reducing anxiety and stress, improving self-esteem and self-efficacy, and disrupting negative thoughts about sexual activity (Kharaghani et al., 2020; Nezamnia et al. 2020). Clients may hold unrealistic expectations about sexuality and sexual functioning, so one goal

of cognitive interventions may be to help the client develop new expectations that are more realistic (Juergens et al., 2009; Jaderek & Lew-Starowicz, 2019). Some clients may benefit from cognitive restructuring (Althof, 2010), identifying and changing negative thoughts (e.g., "My body is unattractive," or "Everyone is having better sex than me") to more adaptive and realistic thoughts (e.g., "There are things I would like to change about my body and things I enjoy about my body," or "Sex looks different for everyone"). Other clients may benefit from cognitive defusion techniques from third-wave CBT approaches, in which the goal is not to change negative thoughts themselves but rather one's relationship to their thoughts through observation and becoming more mindful (Enjezab et al. 2021).

It is important for counselors working with marginalized populations to consider the language they use when addressing clients' thoughts or experiences related to discrimination or stigmatization (Pope et al., 2024c). Thoughts such as, "I'll never find a partner who wants to be with me since I'm overweight," "Something is wrong with me because I don't want to have sex," or "I could enjoy sex if only I could get rid of my disability," are all thoughts that can contribute to feelings of anxiety, inadequacy, or isolation. These thoughts, however, are grounded in existent societal stigmas, such as sizeism, sex-normativity, and ableism. Labeling thoughts related to lived experiences of marginalization as "distortions" or "irrational" inappropriately locates the problem within the individual (i.e., "Just change what you think!") rather than the oppressive systems that perpetuate such views in the first place, potentially harming already vulnerable populations. Rather, counselors can avoid labeling thoughts when utilizing cognitive interventions and help clients situate their cognitive appraisals and associated emotional responses in their past and current experiences of marginalization (e.g., *"Where does that thought come from?"*) or as a realistic response to stereotyping and stigmatization (e.g., *"How does this thought protect you? How does that thought reinforce what society tells you about yourself?"*) (Spencer et al., 2016; VanLandingham et al. 2022).

Moreover, the focus on self is a central element in CBT; however, in marginalized populations and clients from collectivistic backgrounds, an individual's self-concept and healing are often closely tied to their relationships with family and community (Engelbrecht & Jobson, 2016). Hence, counselors should explore how clients' cognitive appraisals not only influence their self-concept and well-being, but also how these appraisals may be contributing to their sense of disconnection from others and potentially reinforcing their distress. Integrating approaches such as RCT (Jordan, 2017) with CBT can guide counselors in adapting cognitive interventions to validate the experiences and meet the needs of diverse populations.

Mindfulness-Based Interventions

Mindfulness focuses on helping clients be more present, intentional, and aware of the current moment and their enjoyment of sexual experiences (Althof, 2010; Flaherty et al., 2024; Jaderek & Lew-Starowicz, 2019). Dissociation and disconnection with one's body and mind can contribute to sexual dysfunctions and interpersonal problems; mindfulness-based interventions teach clients to cultivate focus on their physical and emotional sensations in the moment without judging themselves (Althof, 2010; Blycker & Potenza, 2018). Further, mindfulness promotes

acceptance and self-compassion, which can shift how clients relate to unpleasant thoughts, emotions, or physiological sensation, disrupting negative thought cycles and improving coping with negative emotional states (Jaderek & Lew-Starowicz, 2019). In addition to targeting openness to sexual experiences and enhancing subjective sexual satisfaction, mindfulness may help clients make healthier and informed sexual decisions as they increase interoceptive awareness (Blycker & Potenza, 2018). Mindfulness-based approaches have been used to improve sexual functioning with clients experiencing depression, sexual arousal and desire problems, survivors of childhood sexual abuse, people recovering from physical illnesses such as cancer, and people with compulsive sexual behaviors (Althof, 2010; Blycker & Potenza, 2018; Gorman et al. 2021; Jaderek & Lew-Starowicz, 2019).

Kegels, or clinch-and-release exercises of the pelvic floor, are a specific mindfulness exercise that can enhance pelvic floor health and sexual functioning (Hassan, 2020). The release part of Kegel exercises is just as essential as the tightening, as Kegels are used not only to strengthen the pelvic floor but also increase awareness of relaxation in the pelvic region. Further, pelvic floor relaxation targets overactivity in the pelvic floor region which can stem from trauma exposure, improving urinary and bladder control for all genders and reducing gentio-pelvic pain during sexual activities for women (Dominoni et al., 2024; Karsten et al., 2020). Further, pelvic floor relaxation eases pressure on the vagus nerve and engages the parasympathetic nervous system, both which are helpful to self-regulation training in trauma-informed treatment (Bonaz et al., 2017; Krassioukov & Elliott, 2017). We strongly recommend that counselors refer clients who may benefit from pelvic floor training to medical providers, as physical therapists can assess clients' unique physiological needs, utilize biofeedback, and other physiotherapeutic techniques to rehabilitate the pelvic floor (Rodas & García-Perdomo, 2018).

Skills-Focused Interventions

Through counseling, clients can learn and implement new skills to help enhance their sexual functioning and interpersonal relationships. In addition to mindfulness training, clients may benefit from learning self-regulation strategies, coping skills, and relationship-strengthening techniques. Motivational interviewing and behavioral interventions targeting decision-making, problem solving, and communication skills are helpful in reducing risky sexual behavior and promoting healthy sexual practices, such as use of barrier protection and regular STI/HIV testing (Brookmeyer et al., 2016; Henderson et al., 2020). Additionally, sexual assertiveness training that teaches clients how to clearly and confidently communicate their sexual desires, needs, and boundaries in relationships not only improves healthy sexual behavior, but also contributes to positive sexual functioning and sexual satisfaction (Alvarado et al., 2020; Sayyadi et al., 2019). Sexual assertiveness training targets skills such as how to actively seek consent in sexual encounters, set boundaries before and during sexual activities, talk about sex openly with partners, and recognize potential signs of abusive behavior from partners. Engaging clients in positive identity development exercises, such as journaling, creating self-concept maps, identifying positive role models or media representations, and cultivating authentic and supportive interpersonal relationships, can mitigate marginalization stress and stereotype

threat for clients impacted by oppression (Dyar & London, 2018; Flanders et al., 2017; VanLandingham et al., 2022).

Homework

CBT often incorporates homework that clients complete outside of the session (Althof, 2010). Homework assignments are designed to help clients change nonproductive behaviors or to practice new skills and techniques learned in session. Homework may come in the form of suggested readings or keeping a log of sexual activities, along with corresponding emotions or relationship patterns.

One of the most widely used homework interventions in sex therapy is sensate focus exercises, developed by Masters and Johnson in the 1960s (Althof, 2010; Avery-Clark et al., 2019; Binik & Meana, 2009; Seal & Meston, 2020; Stinson, 2009). Sensate focus exercises are a form of structured discovery through mindful touch that involves exploring one's own and their partners' bodies in non-demanding or achievement-oriented (e.g., not trying to obtain pleasure, arousal, or orgasm for oneself or their partner) ways (Avery-Clark et al., 2019; Seal & Meston, 2020). Sensate focus exercises often involve nonsexual intimate contact with oneself or between partners, with the focus on one's own present moment interest and sensations (Southern & Cade, 2011). Sensate focus exercises move through different levels of touching, refraining at first from touching breasts and genitals, moving toward full body touch with self-directed stimulation (Seal & Meston, 2020; Southern & Cade, 2011). The goal is to reduce sexual and performance anxiety by engaging in touch without pressure or the fear of failure, confronting experiential avoidance as one directs their attention to physical sensations (Avery-Clark et al., 2019). Therefore, each person is guided to learn about their own bodies through the exercises with an emphasis on greater attention to the process of the experience, rather than just focusing on sexual outcomes.

A secondary application of sensate focus exercises involves focusing on interpersonal verbal and physical exploration with one's partner(s), exploring arousal, pleasure, relaxation, and enjoyment in a nondemanding manner (Avery-Clark et al., 2019). Again, the goal is not on outcomes, such as having intercourse or orgasm, but on increasing connection, engagement, and intimacy with one's partner(s). Clients aim to develop increasing awareness of the physical sensations in their bodies, a broader range of sexual behaviors, and a greater focus on foreplay (Southern & Cade, 2011; Stinson, 2009). An important assumption underlying sensate focus exercises is that every person is the expert in their own sexual functioning (Southern & Cade, 2011).

Sensate focus is often utilized in conjunction with CBT and mindfulness practice. The intervention has been found to be effective in improving sexual functioning issues stemming from a variety of factors, including sexual disorders, physical illnesses (e.g., cancer, spinal cord injuries), chronic pain, and sexual and other types of trauma (Avery-Clark et al., 2019; Seal & Meston, 2020). Within intimate relationships, sensate focus exercises can create a solid foundation of good communication, intimacy, love, support, and understanding (Southern & Cade, 2011). To ensure they are using sensate focus appropriately and effectively, counselors should obtain

additional training and supervision in this area prior to introducing sensate focus techniques to clients.

Systemic Therapies

Systems theory allows sexuality counselors to consider multiple systemic levels that impact clients' sexuality beliefs, behaviors, and experiences (Binik & Meana, 2009; Jones et al., 2011). These systems extend from the person's biological systems to relational and broader social systems (Jones et al., 2011). The relational systems that impact clients' sexuality may include their family system, peer systems, and the intimate relationship system (Jones et al., 2011). Systemic influences can impact virtually every aspect of clients' sexuality, from their beliefs and values to their expectations within sexual encounters to their comfort with talking about sexuality in different contexts (Jones et al., 2011). Systems theory provides a foundation for both assessment and interventions in sexuality counseling. In particular, counselors can educate clients about resources and information available about sexuality at various systemic levels. This information can facilitate discussion of the various systemic influences on each client's sexual development, which may offer insights into creating positive change.

Because sexuality is largely expressed within the context of intimate relationships, couples and relationship therapy are often used in sexuality counseling (Althof, 2010). When addressing sexuality concerns in a relationship context, counselors must help partners navigate the balance between respecting each other's needs and boundaries, in that one's preferences may conflict with their partners' range of perceived acceptable behaviors. Increasingly, efforts have been made to integrate sex therapy with couples and relationship therapy, as addressing relational concerns when treating sexual problems is critical (Johnson et al., 2018). Historically, however, these two areas have not been well connected to one another (Zumaya et al., 1999).

One treatment approach that has been applied to sexuality counseling with intimate partners is emotionally focused therapy (EFT; Johnson, 2017; Johnson et al., 2018). EFT applies attachment theory to understanding the role of sexuality within intimate relationships. EFT emphasizes the influence of attachment style on clients' experiences of sexuality, in that secure attachments offer support for taking risks and fostering positive growth. In contrast, insecure attachment styles can lead to greater negative emotionality, distress, and detachment. Within EFT, the lens of attachment theory offers therapists a lens into how and why clients experience sexuality concerns the way they do. Sexuality, therefore, becomes an entree into clients' inner working models that impact how they relate to others. Clients' attachment styles can impact their sexual functioning through such factors as anxiety about body image, their emotional engagement during sexual activity, preferences for physical affection, and how partners make sexual requests of one another. We review EFT in more depth, as well as other approaches to couples and relationship therapy, in Chapter 8.

Collaboration With Medical Providers

The over-medicalization of sexuality has been criticized by some professionals, who argue that the emphasis on medical interventions and understandings overlooks many other important

influences on sexual wellness (Tiefer, 2012; Giami, 2023). In particular, some scholars believe that sexual problems are complex and contextual and therefore are more suitable for psychosocial interventions (Graham, 2007; Pacey, 2008). Overemphasizing the medical aspects of sexuality also runs the risk of devaluing and neglecting the diversity of sexual experiences and expressions (Tiefer, 2012; Giami, 2023) or pathologizing normal physiological changes that impact sexual functioning (Goyal et al., 2022). However, there are a variety of physiological contributors to sexual challenges that may warrant medical intervention. Further, clients often seek, and even may prefer, medical interventions to counseling and therapy, and medical interventions can be used as an adjunct to counseling. In recent years, the field of sexology has moved toward an integration of medical and nonmedical interventions as a means of improving individual's overall sexual health (Goyal et al., 2022; Krakowsky & Grober, 2018). Therefore, counselors should have a basic understanding of how medical interventions can support their clients' sexual wellness, as well as be equipped to engage in interdisciplinary collaborations with medical professionals.

As discussed earlier in the chapter, counselors should inquire about clients' medical history and interactions with healthcare providers during the intake interview. Counselors can support clients by addressing barriers they may have to seeking healthcare, such as financial limitations or fears of minimization or discrimination from providers, and support clients in how to have conversations about sex and sexuality with medical professionals. Common medical conditions that impact sexual functioning include chronic pain, cardiovascular or other illnesses that impact blood flow, and neurological or nervous system disorders (e.g., Parkinson's, strokes). Additionally, hormone imbalances can occur for a variety of reasons, either due to medical conditions such as thyroid disorders or polycystic ovarian syndrome, or due to normative physiological changes associated with aging.

Medication is a common medical treatment for sexual functioning concerns. Historically, medications were initially designed and approved to treat men's sexual functioning, although the pharmaceutical industry has invested more in medications to treat women's sexual functioning in over the past decade after the success of Viagra (Krakowsky & Grober, 2018). Medications that increase blood flow to the genitals, such as Viagra (sildenafil) and Cialis (tadalafil), are commonly prescribed to treat erectile dysfunction in men, and sometimes prescribed to treat low sexual arousal and desire in women. More recently, the Food and Drug Administration (FDA) approved Addyi (flibanserin) and Vyleesi (bremelanotide), which are used to treat low sexual desire and arousal in premenopausal women; both drugs act to increase dopamine and norepinephrine activity in the brain (Pachano Pesantez & Clayton, 2021). Medications to treat vaginal dryness and pain, which are common symptoms of perimenopause and menopause as estrogen levels drop, include vaginal estrogen, such as Osphena (ospemifene) and Intrarosa (prasterone) (Cohen & Brown, 2024).

Hormone therapy is another option that can improve sexual functioning in all genders. For TGD people, gender-affirming hormone therapy can have a variety of positive impacts on sexual functioning, including improved body image and increased sexual desire and activity (Holmberg et al., 2019). Although hormone therapy may lower sexual desire and arousal for TGD people, particularly transgender women, counselors should not immediately assume this change is negative or an impairment for TGD clients. Lower sexual desire can be relieving for

some TGD people, particularly if they do not want to engage in sexual activity while transitioning (Holmberg et al., 2019). Testosterone-based treatments also have been used to address sexual functioning, although testosterone therapy has only been approved by the FDA for men and there is limited evidence of the effectiveness in treating women's sexual dysfunctions, particularly for premenopausal women (Mayo Clinic, 2024; Pachano Pesantez & Clayton, 2021; Rizk et al., 2017). There are mixed results regarding the benefit of estrogen therapy on sexual functioning during and after menopause, although physicians may prescribe hormone therapy for people experiencing vaginal dryness and pain during sex (resulting from the thinning of the vaginal tissue) during the menopausal and postmenopausal period (Cohen & Brown, 2024; Mayo Clinic, 2024).

However, medications may have undesirable side effects, such as diarrhea, nausea, and fatigue, and their benefits typically wear off once the medication is no longer taken (de Carufel & Trudel, 2006; Pachano Pesantez & Clayton, 2021). Furthermore, medications do not offer guaranteed positive outcomes, as medications alone are limited in their effectiveness to treat sexual problems because sex is such an inherently relational and emotional issue (Perelman, 2002). Clients using medical interventions for sexual dysfunction should learn about realistic expectations for those treatments (Sadovsky et al., 2011). In part due to the influence of advertisements touting the seemingly quick and easy medical solution to sexual dysfunctions, clients may need information to understand the psychological and relational context for sexual concerns when they first present for treatment (Rowland, 2007).

Other medical treatment options to improve sexual functioning include sexual devices and aids, physical therapy, and surgery. Sexual devices and aids can be used to treat a variety of sexual dysfunctions. Common devices and aids include lubrication and moisturizers, dilators, vibrators, dildos, vacuum clitoral and erection devices, constriction bands, wedges and cushions, mounts, and furniture (Khajehei et al. 2015; Miranda et al., 2019; Smith et al., 2015). Two devices that have FDA approval are the Eros Clitoral Therapy Device for women's sexual arousal and the Viberect, a penile stimulation device used to induce ejaculation in men with spinal cord injuries (Varod & Heruti, 2024). More recently, smart sexual devices have been developed that infuse technological components to track sexual health, including the capability of gathering information about sexual activities and physical responses via biofeedback (Varod & Heruti, 2024).

Beyond sexual aids, physical therapy for pelvic floor rehabilitation can enhance pelvic floor relaxation, core strength, and blood circulation, and may be particularly useful for clients experiencing postpartum or post-surgical recovery or other conditions impacting the pelvic region (e.g., urinary incontinence, chronic pain) (Pedraza et al., 2014; Rosenbaum, 2007). Pelvic floor physical therapy also can benefit TGD people's pelvic floor functioning and may be recommended both prior to and after gender affirming surgeries (Dominoni et al., 2024). Finally, surgical options also can be used to treat sexual dysfunctions. Surgeries can include repair of anatomical issues or removal of painful tissues around the vagina that are contributing to painful sexual experiences (Khajehei et al. 2015) or penile implants and penile vascular surgery are options to treat erectile dysfunction (Karakus & Burnett, 2020; Rodriguez et al., 2017). As with gender-affirming hormone therapy, gender-affirming surgeries can potentially improve

TGD people's body image and sexual functioning post-surgery, although impacts on their overall sexual satisfaction remain less clear (Holmberg et al., 2019). Sling surgery, used to treat urinary incontinence in women, may help reduce involuntary urination during sex but also can have a negative impact on orgasmic function for some women (Szell et al., 2017). Bariatric surgery also has a positive impact on sexual functioning for both women (Loh et al., 2022) and men (Xu et al., 2019). There is a lack of research on how bariatric surgery impacts sexual functioning for TGD people. We review additional treatment options for addressing physiological-related sexual concerns in counseling in Chapter 11.

As we conclude this chapter, think back to the case studies presented at the beginning of the chapter. We invite you to practice assessment and treatment strategies as relevant to one or more of these cases in Exercise 2.3.

Exercise 2.3 Practicing Sexuality Assessment in Counseling

Directions: Choose one of the cases at the beginning of the chapter to role-play in small groups. One person should take on the role of the counselor, one to three people will take on the role of the clients in the case scenarios, and the remaining individuals in the group can observe the role-play.

Firstly, consider what are some of your personal beliefs and values that may influence your work with the selected client(s)? Consider how you can monitor your beliefs and values during the role-play exercise.

Conduct a 10–15 minute role-play of an intake interview to practice a) exploring the client(s)' sexuality-related concerns, and (b) setting at least one counseling goal toward the client(s)' desired changes. Remember to make goals strengths-based, observable, and measurable.

The counselor may want to refer to the sample interview questions in Table 2.1 or the sample questions in later chapters as related to your selected case. Should the counselor feel stuck at any point, they can pause the "session" to allow the observers to provide feedback on the assessment process.

Based on what you learned in this chapter about general approaches to sexuality counseling, what are some interventions that may be effective in addressing the sexuality-related concerns of the client(s)?

Summary

In many ways, sexuality counseling is similar to counseling in general and other specialization areas. Counselors must work to establish a strong therapeutic relationship with their clients, base counseling interventions on solid, clinical-assessment data, use theoretically sound intervention strategies, and track client progress over time. However, the sensitive nature of sexuality concerns provides a unique context for sexuality counseling, as clients (and counselors!) may demonstrate

a high level of discomfort throughout treatment, especially early in the process and when new challenges and issues emerge. Therefore, counselors should build a solid foundation of knowledge about sexuality, as well as a broad repertoire of skills and intervention strategies, in order to best serve clients seeking counseling to address sexuality-related concerns.

Keystones

- It is important to include the assessment of sexuality as part of the overall biopsychosocial assessment of clients' functioning during the intake interview.
- Counselors are well-situated to evaluate individuals' sexual health and to promote healthy sexual practices through their counseling services.
- Clients typically will not initiate conversations about sexuality unless prompted to do so by their health care providers, including counselors and other mental health practitioners, particularly if their presenting concern is not directly linked to sexuality.
- It is important that counselors are matter-of-fact, objective, and comfortable in discussing sexuality with clients so that their personal values and biases do not interfere with clients' openness to share about sexuality-related topics.
- It is important that counselors develop an ease in saying words related to sex and sexuality.
- If clients identify any sexuality-related concerns during the general assessment process, counselors will want to follow up with more specific questions based on their presenting concerns.
- Counselors should use a combination of informal and formal assessment strategies and tools to assess clients' functioning at each influence within the Contextualized Sexuality Model.
- Referrals to medical providers are often needed to rule out physiological causes impacting sexual functioning. Counselors also can address barriers to clients seeking healthcare through counseling.
- Sexuality counseling treatment plans should be grounded firmly in data collected through the counselor's clinical assessment of the client.
- Regardless of the treatment approach used, counselors hold space for clients to explore sensitive topics that can arise when discussing sexuality concerns.
- Critical theories promote culturally responsive sexuality counseling through collaborative therapeutic relationships and systemic change essential to enhancing the sexual wellness of diverse populations.

- Trauma can disrupt sexual functioning in a variety of ways, so trauma-informed treatments often intersect with sexuality counseling.
- Cognitive behavioral therapy is one of the most effective treatments for sexual concerns, using psychoeducation cognitive interventions, mindfulness training, skills training, and homework.
- There are a variety of medical treatments for sexual dysfunctions, so collaboration with medical providers is often an important element of sexuality counseling.
- Given the broad range of approaches to sexuality counseling, counselors have a variety of resources at their disposal to be able to incorporate different theoretical approaches and techniques to meet each client's unique needs.

Additional Resources

- American Association of Sexuality Educators, Counselors, and Therapists (http://www.aasect.org/)
- American Sexual Health Association (http://www.ashasexualhealth.org/)
- Association for Assessment and Research in Counseling (http://aarc-counseling.org)
- Association of Counseling Sexology and Sexual Wellness (https://www.counselingsexology.com)
- Cornell Health: Sexual Health Resources (https://health.cornell.edu/services/sexual-health-care/resources)
- Go Ask Alice! – a resource hub ran by Columbia Health (https://goaskalice.columbia.edu)
- *Handbook of Sexuality-Related Measures* (4th ed.), edited by Robin Milhausen, John Sakaluk, Terri Fisher, Clive Davis, & William Yarber
- Planned Parenthood (https://www.plannedparenthood.org)
- The Trevor Project: LGBTQ+-Friendly Resources for Sexual Health Support (https://www.thetrevorproject.org/resources/article/resources-for-mental-health-support/)
- WebMD's Sexual Health Center (http://www.webmd.com/sex/)
- World Health Organization – Sexual Health (https://www.who.int/health-topics/sexual-health#tab=tab_1)