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Counseling Psychologists' Experiences Addressing Sexual Health of Clients: A Sex-positive Perspective

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COUNSELING PSYCHOLOGISTS' EXPERIENCES ADDRESSING SEXUAL HEALTH OF
CLIENTS:

A SEX-POSITIVE PERSPECTIVE

by

Jennifer M. Watjen

A Dissertation Submitted in
Partial Fulfillment of the
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August 2020

ABSTRACT

COUNSELING PSYCHOLOGISTS' EXPERIENCES ADDRESSING SEXUAL HEALTH OF CLIENTS: A SEX-POSITIVE PERSPECTIVE

by

Jennifer Watjen

The University of Wisconsin-Milwaukee, 2020
Under the Supervision of Professor Nadya Fouad, PhD

This study explored the lived experiences of counseling psychologists in assisting their clients with sexual health needs. Special attention was given to their understanding and feelings of competency in using a sex-positive framework to assist clients with their sexual health. The study used a phenomenological data analysis method to qualitatively study 5 semi-structured interviews of licensed counseling psychologists. Interview questions addressed counseling psychologists' experiences in assisting clients with their sexual health and focused on the following areas: (a) counseling psychology values, (b) professional experiences with sexual health, (c) graduate training experiences in sexual health, and (d) value influences related to sexual health. Ten noteworthy superordinate themes emerged from analysis of the data. All of the participants acknowledged an absence of sexual health training in their graduate training. The need for sexual health training was recognized to be influential in their feelings of competency and comfort in addressing sexual health needs of clients. Further, the connectedness of a sex-positive framework to counseling psychology values highlighted the relevancy of sexual health to the field of counseling psychology. This study serves to suggest the need and benefit for sexual health competency to be integrated into graduate training programs. Thus, providing counseling psychologists with a secure educational framework to gain sexual health competency to provide appropriate support for client sexual health needs.

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Dedicated to
my mother, grandmother
and all of the strong women in my life

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CHAPTER I: INTRODUCTION

Overview

There has been a recent concern raised about how to support psychologists in competently assisting clients with sexual health needs. Special attention has been directed to the need for a focus on sexual health training for psychologists that is framed through a sex-positive lens (Burnes, Singh, & Witherspoon, 2017; Cruz, Greenwald, & Sandil, 2017; Hargons, Mosley, & Steven-Watkins, 2017; Mosher, 2017). The delay in exploring this concern has resulted in feelings of discomfort and incompetency amongst psychologists in treating clients' sexual health needs. Research has suggested that psychologists often fail to inquire about sexual health concerns of clients during therapy, intakes, or assessments due to their uncertainty of how to competently broach sexual health related topics (Haboubi & Lincoln, 2003; Hanzlick & Gaubatz, 2012; Miller & Byers, 2009, Reissing & Giulio, 2010).

Further, these dialogues are often framed through a medicalized lens that focus on disease prevention and risk aspects of sexual health rather than a balanced, holistic approach that conceptualizes sexual health on a continuum (Arakawa, Flanders, & Hatfield, & Heck, 2013; Lewis, 2004; Mosher, 2017). Given the complexity of sexual health needs that exist for clients, this discomfort and uncertainty about how to competently broach sexual health topics can pose an issue for the therapeutic relationship and treatment for the client. Issues can manifest from the psychologists' lack of knowledge regarding sexual health, failure to consider sexual health of their clients, an avoidant attitude regarding sexuality topics, and even a referral to another psychologist (Anderson, 1986; Hays, 2003; Miller & Byers, 2008). Regardless, these issues can

be a catalyst for potential concerns surrounding the ethical responsibilities of psychologist competency in sexual health.

The field of psychology requires competent practices from its professionals. The focus on achieving competent practices is visible in the field's ethical guidelines that hold professionals accountable in protecting the welfare of the client (APA, 2010). The field of psychology views competency as requiring discrete areas of knowledge, skills, and attitudes about the topic of focus (Epstein & Hundert, 2002; Kaslow et al., 2004). Competency-based standards have been developed that require psychologists to acquire the necessary knowledge, training, and experience necessary to assist clients with their treatment (Fouad & Grus, 2014). The ethical guidelines support these standards by requiring that psychologists will "...practice only within the boundaries of their competence..." within all areas of their careers (APA Ethics Code, 2010, Standard 2.01). Operationalization of competency training has been further defined by identifying core professional competencies that convey functional and foundational knowledge, skills, and attitudes required of a professional psychologist (Fouad et al., 2009; Kenkel, 2009; Schulte & Daly, 2009). These benchmarks assess readiness across various stages of training and provide behavioral anchors of essential elements that are necessary for the competency domain. The utility of these competency benchmarks is relevant to all areas of the field and can be used to address individual training needs.

Core professional competencies is applicable to the discussion of sexual health training for psychologists. Although a clear definition of sexual health competency has not be explicitly established, research has suggested that psychologists would benefit from attention to knowledge on sexual health interventions, exploration of self-awareness, diversity of sexuality, and supervision skills (Harris & Hays, 2008; Miller & Byers, 2008; Reissing & Giulio, 2010). The

use of the competency-based training standards specific to individual and cultural diversity, intervention, research/evaluation, and supervision would assist psychologists in building competent sexual health practices. This would provide psychologists with a rich understanding of the nature of sexual health and the knowledge on how to adequately intervene. Research also suggests that psychologists would benefit from knowledge concerning healthy and unhealthy sexual functions and desires that exist amongst individuals across cultural contexts (Edwards & Coleman, 2014; Mosher, 2017; Popovic, 2006). Furthermore, encouragement of self-reflective processes has been suggested to be especially relevant to competent sexual health practices. Self-awareness can assist psychologists in navigating their own attitudes and values that might impact their clinical work (APA Ethics Code, 2010, Principle A). An ongoing and genuine obligation to engaging in self-reflective processes is especially important when exploring a stigmatized subject such as sexuality. Adherence to this competency can aid psychologists in navigating both personal and professional sex-negative messages that might otherwise result in problematic issues with clients. Self-examination also encourages a collaborative process amongst psychologists in exploring the ways that sex-negative messages impact the way they engage with sexuality research (Cruz, Greenwald, & Sandil, 2017; Hargons, Mosley, & Steven-Watkins, 2017; Mosher, 2017; Sloane, 2014). Utilization of competency benchmarks would support psychologists in competently addressing sexual health needs of clients.

Maintenance of competency can also require extended training outside of the clinicians' scope of knowledge and standard training. Psychologists that maintain competency through practice of the ethical standards will also obtain the necessary training where their competency lacks. In regard to sexual health, this requires psychologists to seek out extended training in areas of sexual health that are unfamiliar and unknown to their current knowledge and skill basis.

With the current climate of the sexual health literature for psychologists focused primarily on a disease-based model, this suggests a complete transformation of how psychologists have previously conceptualized sexual health. The shift of focus on sexual health competency has expanded to incorporate a continuum of attitudes and knowledge about sexual health (Arakawa, Flanders, Hatfield, & Heck 2013; Cru, Greenwald, & Sandil, 2017). The standards further consider the issue of unavailable training within the code as follows:

In those emerging areas in which generally recognized standards for preparatory training do not yet exist, psychologists nevertheless take responsible steps to ensure the competence of their work and to protect clients/patients, students, supervisees, research participants, organizational clients, and others from harm.” (APA Ethics Code, 2010, Standard 2.01)

According to this statement, the ethical code accounts for the lack of recognized standards and training available within certain areas. However, the code does not address the potential harm that can arise due to the lack of appropriate resources and training that are unavailable for complex and controversial areas of focus such as human sexuality. Given that sexual health is an innate human behavior, the incorporation of dialogue surrounding sexual health is a necessary component to psychological competency (Laumann, Paik, & Rosen, 1999; Rosen, 2000). With the current foundation of sexual health built from the Diagnostic and Statistical Manual (DSM), psychologists are trained to view sexual health from a medicalized lens that highlights disease and dysfunction related to sexual health (Nogaski, 2015; Lewis, 2004; Popovic, 2006; Tiefer, 2006). However, sexual health competency is far more expansive and requires a thorough exploration in order to promote its breadth. Competency training standards would thus provide psychologists with a framework that builds upon their understanding of sexual health and also

incorporate physical wellness and the importance of exploring safe, pleasurable sexual experiences and relationships (Ivanski & Kohut, 2017; Mosher, 2017; World Health Organization, 2006).

Social and historical events have framed sexual health through a medicalized lens for psychologists (Arakawa, Flanders, Hatfield, & Heck, 2013; Bullough, 1975; Mosher, 2017; Popovic, 2006). Since the preoccupation with the development of contraception for women, the medical field has created a medical basis for intervening in the conversation of sexual health. This discussion was furthered with the introduction of the Diagnostic Statistical Manual and its standardization of pathological behavior related to sex (Fahs, 2014; Zalaquett et al., 2008). Through a medical model focus, psychologists are exposed to biological aspects of sexual functioning and behavior as they pertain to the sexual response cycle and alleviation of symptoms that disrupt this cycle (Bancroft, 2002; Bradley & Fine, 2009; Southern & Cade, 2011; Tiefer, 1991). This narrowly focused scope of sexual health has led to psychologist often focusing on dysfunctions of sex while failing to acknowledge other factors that influence sexual health (Tiefer, 2006; Tiefer, 2012; Zalaquett et al., 2008). This model of practice can hinder a psychologists' conceptualization of sexual health and could pose as a limitation to the therapeutic dialogue. A more comprehensive and inclusive approach to sexual health that incorporates a wellness-oriented framework would therefore benefit the field of psychology.

The incorporation of a sex-positive framework highlights the complexity of sexual health. "Sex-positive" is historically rooted in the feminist movement during a period in which polar views existed about the conceptualization of sexual health and its relation to the social context. More specifically, the movement emerged in response to repressive discourses about sexual health related to topics such as pornography, queer sexualities, and sex education (Duggan &

Hunter, 1995; Fahs, 2014; Glick, 2000). Although definitions have emerged to adopt different conceptual elements, a common theme has remained consistent that suggests sexual health be viewed from a health and wellbeing perspective (Iavnski & Kohut, 2017). A sex-positive framework is sensitive to sexual pleasure, freedom, and diversity, as these variables relate to the individual's personal intersectional identities and sexual experiences. This discourse also emphasizes sexual pleasure and sexual functioning as core components of the human life (Burnes, Singh, & Witherspoon, 2017; Hargons, Mosley, & Steven-Watkins, 2017; WHO, 2006). The field of counseling psychology is one discipline of psychology that has adopted tenants of this framework within its values. Specifically, the sex-positive framework appears to coincide with the guiding ethical principles of the American Psychological Association (APA) to maintain competent practices across the scope of psychological needs of clients. This framework is especially relevant to counseling psychologists who are motivated to promote the diverse needs of their clients.

Counseling psychologists' core values distinguish them from other disciplines of psychology. Counseling psychologists are committed to providing services and engaging with members of social groups that are often systematically marginalized. They are motivated to examine clients through a multicultural and intersectional lens that reflects how the clients' experiences are dynamically influenced by their social context. Additionally, counseling psychologists are committed to critical thinking and encourage self-examination to explore personal prejudices and biases, as they relate to their professional work. In conjunction with their willingness to examine their personal values, professionals that practice counseling psychology also seek to learn culturally relevant knowledge and skills to further their professional development and conceptualization of their client needs. Through these efforts,

counseling psychologists create an environment that encourages respect, safety, and trust for those engaging in the process (Council of Counseling Psychology Training Programs, 2009).

The culturally and socially sensitive values of counseling psychology coincides with the framework of a sex-positive movement. Counseling psychologists' critical analysis of cultural relevance encourages a broader scope of sexual health that can reflect a continuum of sexual attitudes and norms. This continuum connects with a sex-positive framework that promotes the health and wellness of an individual's sexual health through their cultural and social context (Burnes, Singh, & Witherspoon, 2017; Popovic, 2006). For example, this framework aids in exploring the diverse avenues of sexual health and sexual experiences of minority populations such as those within the disabled community or survivors of a terminal illness. A sex-positive framework encourages the development of open, honest communication about their diverse sexual health rather than identifying sexual dysfunction related to their disability of terminal illness (Sloane, 2014; Syme, Mona, & Cameron, 2013). This promotes a holistic view of sexual health by considering how various factors of an individual such as their physical, social, and cultural identities can be influential in their sexual health experiences.

The integration of a sex-positive framework in counseling psychology also promotes the importance of the self-examination. Self-examination is a core value of competency for a counseling psychologist. The exploration of personal values and interpretation of cultural messages related to sex encourages psychologists to examine sexual health in a broader sense. For example, the practice of a sex-positive framework requires that psychologists be committed to examining their beliefs and values related to topics such as polyamory, diverse relationships, and sexual desires and fantasies of their clients (Burnes, Singh, & Witherspoon, 2017; Cruz, Greenwald, & Sandil, 2017). Counseling psychologists that practice under a sex-positive

framework are encouraged to explore their own personal journey with their sexual health and messages they have internalized as a result of their experiences. A critical understanding of their personal beliefs can help promote a supportive environment that encourages promotion of wellbeing and respect. Creation of this safe space can also help decrease potential distress that clients might feel from the social stigma related to their sexual desires and practices. Given that counseling psychology celebrates resilience and strengths-based values, sex-positivity is a critical construct that warrants further investigation from the field of counseling psychology.

With this in mind, this study focused attention on exploring a sex-positive framework of sexual health for counseling psychologists. Specifically, this study highlighted the benefit of encouraging a more comprehensive approach that incorporates values of counseling psychology such as the promotion of strengths, resilience, and social justice. All of these issues are considered with the ethical guidelines of the American Psychological Association (APA) in mind. This study explored counseling psychologists' experiences in addressing sexual health issues with clients through a sex-positive framework. This chapter is intended to offer an overview of the study, including a brief description of related background information, a statement of the problem, and an explanation of why the study is significant to the field of counseling psychology.

Problem Statement

There has been a recent concern raised about how to support psychologists in competently assisting clients with sexual health needs. Special attention has been directed to the need for sexual health training for psychologists that is framed through sex-positive lens (Burnes, Singh, & Witherspoon, 2017; Cruz, Greenwald, & Sandil, 2017; Hargons, Mosley, & Steven-Watkins, 2017; Mosher, 2017). Based on a review of the current literature, few studies have

taken into account the experiences specific to counseling psychologists. Currently, counseling psychologists appear to be practicing from a medicalized model that continues to recognize sexual health as an issue to be fixed or pathologized (Bancroft, 2002; Bradley & Fine, 2009; Southern & Cade, 2011; Zalaquett et al., 2008). This narrowly framed conceptualization of sexual health fails to validate the individual experiences or provide a holistic, wellness-oriented understanding of sexual health. Recent literature has challenged the current model by encouraging counseling psychologist to explore sexual health through a sex-positive framework (Burnes, Singh, & Witherspoon, 2017; Cruz, Greenwald, & Sandil, 2017; Mosher, 2017; Williams, Prior, & Wegner, 2013). However, the current literature lacks substance in how counseling psychology's values are congruent with a sex-positive framework and counseling psychologists' understanding of this approach. The paucity of research within this area further warrants practical implications for competency or ethical concerns related to the field of counseling psychology. To date, research has also been focused on quantitative or conceptual frameworks and has failed to utilize qualitative methodologies to explore the experiences of counseling psychologists (Hargons, Mosley, & Steven-Watkins, 2017; Parritt & O'Callaghan, 2000). Given that sex and the understanding of sexual health is an intimate topic, expanding the methods of inquiry could shed new light on the discourse of sex-positivity in counseling psychology that prior methods have highlighted.

Purpose of the Study

The purpose of this phenomenological qualitative study is to investigate the experiences of counseling psychologists in working with client sexual health needs. Specifically, this study will explore how their approaches and conceptualization of sexual health aligns to a sex-positive framework. Exploring the lived experiences of counseling psychologists regarding the utility of

sexual health interventions will provide insight into furthering the didactic training through a sex-positive framework.

To access the ways that counseling psychologists are exploring client sexual health is essential to furthering support for professionals. Research questions were developed to determine how counseling psychologists personally and professionally approach sexual health issues through the lens of a sex-positive framework. This study attempted to answer the following research questions:

1. What have counseling psychologists experienced in assisting clients with their sexual health?
 - a. How do counseling psychologists feel about their sexual health competency?
 - b. What meaning do counseling psychologists apply to a sex-positive framework?
 - c. What experiences have counseling psychologists had with sexual health training within their graduate programs and outside of their programs?
 - d. What role do counseling psychology values play in the experiences of counseling psychologists in assisting clients with their sexual health?
 - e. What role does the counseling psychologists' personal values play in assisting clients with their sexual health?

The researchers' goal was to identify themes in the conceptualization of sexual health with the intention to highlight areas of concentration for future training and research.

Additionally, the goal was to provide a basis for developing a sexual health wellness-oriented model that incorporates sex-positive fundamentals relevant to the values of counseling psychologists.

Significance of the Study

The current study is significant because the framework offers various contributions to the current body of research. First, this study provided information about the meaning that counseling psychologists apply to the construct of sexual health and how that meaning informs their practice with clients. Second, this study increased awareness and insight regarding counseling psychologists' experiences and utilization of sex-positive approaches in assisting clients with their sexual health. This can also provide further insight into how the values of counseling psychologists coincide with the goals of a sex-positive approach. Finally, this study provided an opportunity to make recommendations for the improvement of sexual health training and competency standards for future counseling psychologists.

Understanding the experiences of counseling psychologists is significant in clarifying the professional stance on sexual health that currently guides the framework to educate and train counseling psychologists. Further, this study provided a basis for discussion about how to support counseling psychologists in obtaining adequate sexual health knowledge, awareness, and skills. Creating a dialogue that promotes the inclusion of sexual health in counseling psychology can encourage educators to develop ways to incorporate sexual health into graduate training. The results of this study also provided information to better understand how to support counseling psychologists in competently practicing from a sex-positive framework that is sensitive to the wellbeing and individual needs of the client.

Professional Relevance

This study addresses numerous central themes that are core to the field of counseling psychology. One primary focus for counseling psychologists is the importance of viewing clients from a balanced, holistic viewpoint over the progression of their lifespan. This process is

also paralleled with the utility of exploring this progression through the use of a strengths-based lens. These focuses are congruent with the goals of a sex-positive framework in which counseling psychologists actively explore sexual health on a continuum with respect to the wellbeing and sexual experiences of the client. Counseling psychologists also normalize the importance of highlighting the individual experience from the person's social and cultural standpoint. Especially relevant to a sex-positive framework, counseling psychologists using this approach are sensitive to the individual and unique experiences of sexual health amongst individuals across cultural contexts. This framework emphasizes the importance of empowering clients to explore the role intersectionality plays in their sexual experiences and desires. Lastly, social justice is a premier focus for the field of counseling psychology that actively seeks to advocate for members of marginalized populations through clinical and educational avenues. A sex-positive framework encourages counseling psychologists to advocate for more inclusive sexual health training and competency standards that can adequately assist clients from diverse contexts. As highlighted, the values of counseling psychology and a sex-positive framework of sexual health provide further basis for exploring how their connectivity can be incorporated into the field.

Definition of Terms

Competence – "...the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served (Epstein & Hundert, 2002)."

Medical Model – "In the medical model, (a) the client presents with a disorder, problem, or complaint; (b) there exists a psychological explanation for the disorder, problem, or complaint; (c) the theoretical conceptualization and knowledge are sufficient to posit a

psychological mechanism of change; (d) the therapist administers a set of therapeutic ingredients that are logically derived from the psychological explanation and the mechanism of change; and (e) the benefits of psychotherapy are due, for the most part, to the specific ingredients. The last component, which is often referred to as specificity, is critical to the medical model of psychotherapy and gives primacy to the specific ingredients rather than common or contextual factors (Wampold, Ahn, & Coleman, 2001).”

Medicalization – “...consists of defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to treat it (Conrad, 1992).”

Phenomenology – “Phenomenology’s task is thus to bring structures of consciousness like perception and memory to direct givenness and investigate them according to their essence (Aagaard, 2017). “

Sexuality – “...a central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles and relationships. While sexuality can include all 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 (WHO, 2006a).”

Sexual health – “...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 (WHO, 2006a).”

Sex-positivity – As a theoretical framework, acknowledges pleasure, freedom, and diversity. The sex positive framework has been developed with eight dimensions: (a) “positive” refers to strengths, wellbeing, and happiness; (b) individual sexuality is unique and multifaceted; (c) positive sexuality embraces multiple ways of knowing; (d) positive sexuality reflects professional ethics; (e) positive sexuality promotes open, honest communication; (f) positive sexuality is humanizing; (g) positive sexuality encourages peacemaking; (h) positive sexuality is applicable across all social structures (Hargons, Mosley, & Steven-Watkins, 2017; Williams, Thomas, Prior, & Walters, 2015).

Summary

This chapter has attempted to provide an overview of the need to extend the literature on counseling psychologists’ experiences in assisting clients with their sexual health needs is relevant to the field. Further, this chapter has also highlighted the need for further inquiry to address the appropriateness for counseling psychologists to practice from a sex-positive framework. This study used a phenomenological qualitative design to examine counseling psychologists’ understanding and practices of sex-positive interventions in their work with clients. The next chapter will provide an expanded overview on the literature pertaining to psychologists’ feelings of competency and approaches to sexual health needs of clients, current graduate training practices of sexual health for psychologists, sexual health competency and its relevance to counseling psychology, and literature defining a sex-positive framework for counseling psychologists and its connection to their professional values. Chapter 3 will provide an explanation of the phenomenological qualitative research design used for this study. The final

two chapters report the results and implications for counseling psychologist education, training, and directions for future research.

CHAPTER II: LITERATURE REVIEW

Overview

As indicated in Chapter I, the study examined concerns raised about counseling psychologist competency in assisting clients with sexual health needs. Specific attention was given to sexual health training for counseling psychologists focused through a sex-positive framework. This chapter provides a review of literature that is relevant to this study. First, literature describing competency within the field of psychology and its relevance to sexual health of psychologists will be described. The second section of this chapter will review the current trend in sexual health literature through a medicalized model and provide a critique of the current framework about how the current model has influenced psychologist sexual health training and practice. The third section of the chapter reviews research that examines the relation of values between counseling psychology and a sexual health sex-positive framework.

Competency

This section covers the development of the competency movement in psychology and highlights some of the concerns with maintaining competency after graduation. While there are clearly demarked competency benchmarks for doctoral training, benchmarks for postdoctoral training have not been developed.

Standards for professional competency provide technical and behavioral outlines for practice. Professional associations have made significant efforts to adequately define competency and identify key elements that provide utility to the profession. Although variations of competency elements exist, common themes have emerged from the construct that is relevant to various professions. Competence has been recognized within various professions as “the

habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotion, values, and reflection in the daily practice for the benefit of the individual and community being served” (Epstein & Hundert, 2002, p. 226). Competence also reflects the individual’s performance at a standardized level that is dependent upon the context and person’s developmental stage. Distinctive components of competence are conceptualized as competencies and consist of discrete knowledge, skills, attitudes (Kaslow, 2004). Although aspirational in nature, the utility of these terminologies has been translated into observable and measurable goals training professionals incorporate into their standards to reflect appropriate standards of practice. The process of competence is a life-long process that is continued through learning in practice that ensures professionals are striving to provide safe and adequate care.

Psychology has responded to the paradigm shift to incorporate competency-based standards into its profession. The discussion of competency has continued to be a topic of conversation amongst professional psychologists since the mid-1980s when a basic competency model was developed by the National Council of Schools and Programs of Professional Psychology (NCSPP) to suggest training standards (Nelson, 2007; Peterson, Peterson, Abrams, & Stricker, 1997). The progression of this conversation led to the APA requiring training programs to specify their training objectives in relation to expected competencies to be obtained by graduates (APA, 1996). Further, professionals in the field worked together to identify essential elements and behavioral cues for professional development. These training implications were reflected in the development of the Competency Cube at the Competencies Conference in 2002 that proposed foundational and functional competencies that are relevant at various stages of professional development and acknowledged by training programs. The foundational competencies are recognized to reflect the skills, values, and attitudes that lay the

groundwork for psychologists to engage in the functional competencies. More specifically, foundational competencies reflect areas such as an understanding of ethics, an awareness and understanding of individual and cultural diversity issues, and knowledge of the scientific foundations of psychology. Functional skills, on the other hand, reflect areas of growth such as assessment, intervention, and research (Rodolfa et al., 2005). The introduction of competency models in psychology has continued to flourish in an effort to support training programs in tracing the development of its trainees.

The field of professional psychology has most recently encouraged a shift in its assessment of competencies. Stemming from the framework of the Competency Cube, Fouad et al. (2009) expanded the model and created the Competency Benchmarks that acknowledged the depth of each competency and the behavioral markers for different developmental stages. The Competency Benchmarks has provided an operational definition of each competency and used behavioral anchors to identify essential elements at varying levels of training. Specifically, the behavioral anchors signify increasing independent growth at the trainees' readiness for practicum, readiness for internship, and readiness for entry into practice. For example, the reflective practice/self-assessment/self-care competence is defined as "practice conducted with personal and professional self-awareness and reflection; with awareness of competencies; with appropriate self-care." A behavioral anchor for readiness for practicum would be developmentally appropriate and would encourage critical thinking of oneself whereas a behavioral anchor for readiness for internship would reflect further growth in development and would require the trainee to recognize impact of self on other. Therefore, the use of the behavioral anchors identifies thresholds of competence at the different stages of trainee development. The use of this model allows training programs to identify a succession of

coursework throughout training that builds upon the competencies. Further, this framework also allows for the development of individual competency by individualizing the trainees' assessment of their competency level throughout the progression of their professional career (Donovan & Ponce, 2009; Fouad et al., 2009; Hatcher et al., 2013). The competence models provide a framework for identifying the developmental of competent practices of its professionals in an effort to maintain professional standards.

The focus on competency has been recognized by the APA as a reflective practice of ethicality. The 2002 Ethics Code recognizes competence as a primary concentration that encourages its professionals to seek ongoing development within the profession. Competent psychologists begin by practicing the aspirational values of Beneficence and Maleficence in which, "Psychologists strive to benefit those with whom they work and take care to do no harm (General Principles section, para. 2)." Psychologists benefit their clients by practicing competently and avoiding harm to their clients whereas incompetence can increase the risk of harm. However, the Ethical Principles of Psychologists and Code of Conduct (APA Ethics Code, 2010) recognize competence not only as an aspirational principle but also as a required standard. The ethics code requires its clinicians to "...provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience (APA Ethics Code, 2.01)." Psychologists respectively gain knowledge, skills, and awareness of basic assessment, diagnostics, and interventions that can be further extended their area of interest (Barnett, Doll, Younggren, & Rubin, 2007). In light of the field's recent focus on cultural diversity, competent professionals are also sensitive to diversity issues as they relate to the context of their clients and the clinical work (Comas-Diaz & Caldwell-Colbert, 2006; Fouad,

2006; Rodolfa et al., 2005; Wise, 2008). Competency is also acknowledged as an ongoing process that requires attention to the development of the profession through continued knowledge of the growing literature and development of new clinical skills. This is encouraged by the field through continuing education requirements that are necessary for licensure renewal (Barnett, Doll, Younggren, & Rubin, 2007; Kerns, Frantsve, Berry, & Linton, 2009; Overholster & Fine, 1990). The existence of competency-based measures and requirement of continuing education aim to develop competent professionals for the field.

However, while the field has focused on the attainment of competence, there are also concerns when competence is not achieved, or perceived to not be achieved. Uncertainty about individual level of competency can hinder professional work and bring about potential ethical concerns. Although competency guidelines have been set for the field, further discussion as to individual implications of competency seems to be warranted. Due to the multidimensional nature of competence, psychologists often experience feelings of incompetence (FOI) about their effectiveness with clients that can pose an issue for their personal wellbeing and the welfare of their clients (Mahoney, 1991; Theriault & Gazzola, 2006; Theriault & Gazzola, 2010; Zhao et al., 2011). Although feelings of incompetence have been reported by therapists of varying levels, they are especially prevalent in novice clinicians (Orlinsky et al., 1999; Theriault & Gazzola, 2006). On a personal level, feelings of incompetence can lead to stress and burnout, depression, and premature career change (Hannigan et al, 2004; Mahoney, 1997; Theriault, 2003). These issues can in return cause ruptures in their clinical work in which the clinician becomes withdrawn from clients, engages in early or delayed termination, or hinders the therapeutic relationship (Bradley et al., 1996; Theriault & Gazzola, 2006; Watson & Greenberg, 2006). Knapp and VandeCreek (2006) refer to these challenges as issues with the psychologists'

emotional competence that requires ongoing engagement in self-care and self-reflective practices. Although empirical research does not currently exist to suggest a connection between feelings of incompetence and incompetent behavior, the argument can be made that the outcome of FOI can pose ethical concerns. Failure to attend to the individual emotional competence of psychologists might lead to unethical behaviors.

Further concerns about individual level of competency and its ethical implications have been made regarding psychologist competency after licensure. Required review and feedback are often halted and the continuation of learning is expectedly upheld through the practice of continuing education credits for licensure renewal. Although the intent of continuing education is to update psychologists on relevant developments within their field, the effectiveness of their ability to ensure competency maintenance is suggested to be questionable (Barnett, Younggren, Doll, & Rubin, 2007; Neimeyer, Taylor, & Wear, 2009; Neimeyer, Taylor, & Phillip, 2010).

First, the distinction of what constitutes sufficient continuing education and its purpose in psychologist development is unclear and often inconsistent amongst state licensing boards (Daniels & Walter, 2002, Fagan et al., 2007). The lack of standardized protocols for state continuing education can result in practicing professionals failing to obtain varying degrees of competencies or failing to obtain necessary competency in certain areas of the field (Kerns, Franstve, Berry, & Linton, 2009). For example, Miller & Byers (2009) assessed continuing education of psychologists regarding sexuality and found that psychologists were rarely provided with observational opportunities and often obtained training related to sexual dysfunction rather than healthy sexual functioning or the continuum of sexual health needs of clients. Observational learning was defined as observing another clinician provide therapeutic services to a client regarding their sexual health either through a videotaped or live session. This type of

learning style has been suggested to be an important method to use for skill development that can aid in increasing a learners' feeling of self-efficacy (Hudson, 2007; Miller & Byer, 2008).

Observational learning also provides the learner with the opportunity to inquire about methods used during the observation or obtain constructive feedback (Miller & Byers, 2010). Given the sensitive nature of the topic, this inconsistency in continuing education experiences can influence the level of competency and quality of care for clients if the clinician does not seek further training to fill the gaps.

Second, psychologists are often responsible for selecting their continuing education experiences and might neglect certain areas of practice due to lack of interest or discomfort (Barnett, Younggren, Doll, & Rubin, 2007; Kerns, Franstve, Berry, & Linton, 2009). For example, Neimeyer, Taylor, & Phillip (2010) conducted a study that surveyed psychologists' pattern of participation in continuing education and found that participants often selected continuing education opportunities based solely on their interests and needs of their workplace. Specifically, research has suggested that continuing education training often focuses on topics such as professional ethics, depression, anxiety disorders, and assessment (Neimeyer et al. 2000). This limited scope of extended training can create a disconnect of psychologist competency if the topic area is not of interest or the psychologist does not deem the training applicable to their direct professional functions. Given that continuing education trainings are not designed to remediate practitioner biases or address professional impairment, psychologists can continue to perpetuate incompetence in certain areas such as topics related to sexual health (Melnik et al., 2001).

Lastly, relatively little is known about the current impact of continuing education and its effectiveness in maintaining professional competencies in psychology. Currently, participant

satisfaction surveys are the primary measure for identifying outcomes of the continuing education experiences and the utility of this form of measure has been seen as concerning (Neimeyer, Taylor, & Wear, 2009; VandeCreek et al., 1990). The uncertainties with continuing education in professional psychology warrant further questions about their ability to aid psychologists in maintaining competency after licensure. Specifically, the maintenance of competency in certain topic areas and its potential implications for practice continues to be of concern.

Competency within the field of psychology has continued to progress. However, concerns about individual level of competency after graduation have remained. The uncertainty about the utility of continuing education and the topics often explored in continuing education training has also been suggested to be potential concerns for professional psychology competence. This uncertainty regarding competence after graduation may also pose concerns for psychologists' abilities to assist clients with certain topics that are outside of the scope of supported training.

Medicalization in Psychology

This section defines medicalization and its influence on the current classification system utilized by licensed psychologists. A critique of how the medicalized framework has been suggested to limit the scope of practice for psychologists is discussed. Specifically, attention is given to the medicalization of sexual health and limitations that are present in the current research.

The innate nature of human sexual health is an area of psychological functioning that is relevant to all clients. Clients' realm of experiences is often linked to their physical and emotional wellbeing. When assessing psychologist competency in sexual health, this requires

that psychologists possess knowledge across the spectrum of sexual health. Their knowledge therefore encompasses a broad understanding of healthy and unhealthy sexual functioning and desires. For example, The World Health Organization (2006) 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 sex and sexual relationships, as well as the right to have 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.” This definition highlights the importance of approaching client sexual health needs from a holistic perspective that is sensitive to the spectrum of their desires and sexual functions. However, the current landscape of the literature suggests that psychologists are often provided with a medicalized view of client health needs that might limit their scope of practice (Cacchioni & Tiefer, 2012; Cruz, Greenwald, & Sandil, 2017; Lewis, 2004; Zalaquett, Fuerth, Stein, Ivey, & Ivey, 2008).

The onset of the Diagnostic Statistical Manual (DSM) in psychology shaped the focus of the field. Due to its vague and unclear diagnostic interpretations, drastic changes were made to an original version of the diagnostic model, the DSM-II, in order to create a reliable diagnostic framework. The creation of the DSM-III in 1980 provided psychologists with an empirically based document to foster scientific diagnoses and treatment options that emulate general medical practices. Similar to a medical model, the diagnostic model in psychology adopted a process of characterizing pathological and clinical findings, exploring a known course for the pathology, and providing specific responses to treatment (Galatzer-Levy & Galatzer-Levy, 2007; Pilecki, Clegg, & McKay, 2011; Zalaquett, Fuerth, Stein, Ivey, & Ivey, 2008). This model assumes that

deviation from a normative pattern of functioning can result in dysfunction or distress that can be characterized by classifications in the DSM and provide a basis for empirical treatment interventions. An extension of Emil Kraepelin's original biological etiology, this approach became known as the Neo-Kraepelinianism and resulted from a response to Freud's earlier approaches to psychiatric diagnostics that consisted of unproven and inconsistent psychodynamic concepts. The Neo-Kraepelinianism intended to identify the biological or "natural" basis of mental health disorders and organize them into a classification system based on those categories (Hoff, 2015; Galatzer-Levy & Galatzer-Levy, 2007). Since the onset of this framework, the field of psychology has continued to adapt this medical model and incorporate its tenants into the most current psychiatric diagnostic classification models.

The incorporation of a medical process has suggested that the field of psychology has adopted a medicalized model to guide their practices. Conrad (1992) defined medicalization as "...defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to treat it." Scholars have suggested that the social influence of increased prestige and power of the medical profession has encouraged the focus of a medicalized model. Varying entities of authority have adopted a medicalized approach, and as a result, inform the conditions that are defined, diagnosed, and treated by professionals within the field. Specifically, professional psychologists are expected to be proficient in diagnostic classifications set by the APA, educational accreditation guidelines, and insurance companies (Pilecki, Clegg, & McKay, 2010; Tiefer, 2012; Zalaquett, Fuerth, Stein, Ivey, & Ivey, 2008). Each condition within the classification system can experience a degree of medicalization and can be dependent upon the context of the condition. For example, conditions can range on a continuum of medicalization from fully

medicalized to minimally medicalized. Factors that seem to influence the degree of medicalization are the interest posed by the medical field, the existence and accessibility of treatment, the context in which the conditions exist, the presence of existing alternative explanations, the connection of medical insurers to the condition, and the possible level of stigma associated with the condition (Conrad, 1992). The degree of medicalization can also affect the impact of the public the opinion and social policies that ultimately can pose social justice concerns. For example, the medicalization of conditions can impose labels on certain diagnoses that perpetuate stigmas and can determine the allocation of resources to assist individuals with those issues (Conrad & Barker, 2010). Researchers have suggested this to be counterintuitive to the values of psychology when considering that a counseling model often treats psychological conditions in response to life challenges, placed the client as an active agent in treatment, focuses on cultural and contextual variables, and highlights non-psychopharmacological treatment interventions (Zalaquett, Fuerth, Stein, Ivey, & Ivey, 2008). Further, researchers have also suggested that applying a medicalized model to psychiatric issues has allotted the pharmaceutical companies an abundance of power on the treatment interventions provided to clients (Galatzer-Levy & Galatzer-Levy, 2007). While the medicalized model continues to be the most readily used approach by the field of psychology, concerns have been raised about its reliability for the field.

The topic of sexual health is one that continues to be medicalized within the field of psychology. Medicalization of sexuality supports a traditional medical emphasis of the diagnostics and interventions utilized to assist clients with their sexual health (Tiefer, 2012). This encourages clinicians to focus their conceptualization and interpretation of the client's sexual health through a predetermined diagnostic model in which medically supported

interventions take precedence. Further, current research has highlighted the focus on a biomedicalization model that extends the medical model to encourage consumers to view life experiences through a normal versus abnormal lens (Nye, 2003). Concerning sexual health, this encourages the public to place an emphasis on categorizing sexual health topics into healthy or unhealthy norms (Tiefer, 2012). In the American culture, various elements of sexual health are medicalized such as reproductive issues, sexually transmitted diseases, sexual deviations (e.g. sex addiction), and more recently the inclusion of sexual dysfunctions (Conrad, 1992; Giami, 2000).

Sexual dysfunctions currently seem to be at the forefront of the medicalized discussion given its connection to pharmaceutical agendas. In the 1980s, the pharmaceutical companies encouraged a medicalized understanding of sexual dysfunctions in order to encourage public use of the medicine Viagra to aid with male impotence. The term impotence later became recognized as erectile dysfunction in order to create a stronger association with a medical condition and in efforts to reduce potential shame (Loe, 2004). This medicalized interest in sexual health has also recently become of interest for treatment of women. For example, the pharmaceutical industry has started to focus on sexual side effects of medications and sexual effects of various medical conditions (Bancroft, 2002; Giami, 2000). The medicalized developments for sexual dysfunctions have aided in shaping the current focus of sexual health for psychologists by suggesting the framework used to assess and treat sexual health of clients.

Sexual dysfunctions are of particular interest to the psychological community concerning sexual health treatment of clients. Currently, the DSM requires the clinician to assess for alternative explanations to the sexual distress prior to labeling the client's concerns a sexual dysfunction. However, even after those variables have been considered, research has suggested

that sexual dysfunctions are still highly prevalent and complex concerns for clients. Research has suggested that sexual dysfunctions are affecting about 43% of women and 31% of men at some point in their lives (Rosen, 2000). However, the authors acknowledged that prevalence rates for the various sexual dysfunction disorders have often been inconsistent amongst researchers. For example, prevalence rates have suggested that between 10% to 52% for men and 25% to 63% of women experience sexual dysfunctions (Laumann, Paik, & Rosen, 1999). The inconsistencies in prevalence rates can be attributed to flawed methodologies. Few conceptual models have been proposed to adequately categorize or diagnose the disorders and fewer models have taken into account the setting in which these disorders are being reported. Therefore, further clarification regarding standardized definitions for the various sexual dysfunctions and a multidimensional model of physical and psychological determinants has been suggested to be beneficial for future research.

First look at these statistics perpetuates the focus of framing sexual health through a medicalized lens within the field of psychology. Although sexual distress can present a concern for some clients, researchers have criticized sexual dysfunction research for failing to account for diagnostic clarification and also for failing to consider mental health or quality of life issues associated with their present sexual distress (Bancroft, Loftus, & Long, 2003; Tiefer, 2000). Simons & Carey (2001) reviewed a decade of sexual dysfunction literature and found that a majority of the studies failed to incorporate the DSM criteria to diagnose sexual dysfunctions and did not provide an operational definition of the dysfunction being studied. Research has also suggested that the current DSM conceptualization of sexual health for men and women is not representative of the known gender differences. Supporters of this idea have stated that the DSM currently reflects a male model of sexual dysfunction and fails to take into account factors

related to women's sexuality. While the discussion continues about the conceptualization of existing gender differences in sexuality, research has suggested that biological sex continues to shape sexual functioning for men and women (Bancroft & Cawood, 1996). Additionally, although these concerns are suggested to be prevalent, the client's sexual health is often not fully addressed when viewed from a dysfunction and disease-based model (Rosen, 2000). Instead, researchers suggest that sexual health concerns need to be framed from a comprehensive approach that places value on the promotion of exploring and supporting all sexual desires and functions as normative (Burnes, Singh, & Witherspoon, 2017; Hargons, Mosley, & Stevens-Watkins, 2017; Williams, Prior, & Wegner, 2013).

This section discussed how psychology has adopted a medicalized framework for the diagnostic system. Limitations of this model has been suggested to influence the diagnostic and treatment outcomes of specific disorders such as sexual dysfunctions. A critique of the current methodologies used to identify sexual disorders was also highlighted.

Psychologists' Comfort with Sexual Health

This section will discuss psychologist level of comfort in assisting clients with their sexual health needs. Implications for psychologist level of comfort in discussing sexual health with their clients is also addressed.

The psychologists' level of (dis)comfort with sexual health has been suggested to interfere with their ability to competently address the sexual health needs of their clients (Miller & Byers, 2008, Miller & Byers, 2009; Reissing & Giulio, 2010). The deeply personal connection, and taboo nature of sexuality in the Western culture, can induce added anxiety for the psychologist and client. According to a survey sampling of clinical psychologists, many admitted to not asking, or infrequently asking, about the sexual health concerns of their clients.

The lack of discussion was attributed to their lack of knowledge in sexual health and their lack of comfort in training and treatment interventions pertaining to sexual health (Miller & Byers, 2010; Reissing & Giulio, 2010). Although little research has addressed psychologists' comfort with sexual health, one study in particular emphasized the importance of psychologist comfort in addressing sexual health in therapy. Hanzlik & Gaubatz (2012) investigated clinical psychology PsyD trainees' comfort in discussing sexual health of clients and found that participants reported experiencing lower levels of comfort when asked about discussing specific sexual health issues than when they were asked about sexual health from a global perspective. Research has also suggested that professionals are often more comfortable with addressing risk and 'safe-guarding' issues of sexual health rather than on the exploration of their sexual expression (Hughes et al., 2017).

Additionally, trainees' level of comfort also positively correlated with sexual health training and sexual attitude. This research prompts the need for further investigation as to the type of sexual health training that attributed to the trainees' perceived level of comfort. Limitations existed within this research to prompt an expansion of further investigation. For example, limitations of this study were the lack of clarification of what constituted sexual health training and the lack of vignette-based clinical situations to prompt their feelings of comfort in assisting clients with potential sexual health topics they might encounter in session.

Similarly, Harris & Hays (2008) examined family therapists' comfort and willingness to discuss sexual health issues with clients. The authors suggested that the therapists' perceived level of sexual knowledge and supervision experiences processing sexual health issues of clients influenced their comfort with sexual health issues and their willingness to initiate sexuality related discussions. These findings suggest the need for further investigation and clarification of

sexual knowledge and supervision that assist a clinician with their level of comfort. Anderson (1986) suggested the need for psychologists to engage in a process of psychoeducation, as well as a process of self-awareness of their own personal sexual beliefs and attitudes. This process of self-reflection would aid the psychologist in becoming more comfortable in addressing the sexual needs of clients. Anderson (1986) also found that while some psychologists reported being comfortable in addressing sexual issues with their clients, there were often areas related to sexuality that left most psychologists emotionally uncomfortable (i.e. incest or rape). Anderson (1986) used reports from students in his human sexuality course to identify the framework for educating counselors in training on human sexuality topics. Empirical research does not currently exist to support the utility of this model and has been noted as a limitation of this study. This discomfort and lack of engagement surrounding sexual health may suggest that psychologists overlook or avoid pertinent issues that may be related to the client's needs. Due to their discomfort, psychologists might be inadequately assessing sexual health and failing to provide comprehensive care to clients. Failure to adequately treat or avoid their clients' sexual health issues may pose further harm to the client.

This section discussed the limited research on psychologist level of comfort in discussing sexual health with clients. Further research on psychologist comfort in addressing sexual health and its impact on the therapeutic relationship was addressed due to its utility to their field.

Graduate Training in Sexual Health

This section addresses concerns related to graduate training for professional psychologists in sexual health. The impact of limited graduate training in sexual health on psychologist competency is highlighted. Also, concerns related to suggested insufficient training in sexual health for professional psychology graduate students are discussed.

The presence of psychologists' discomfort surrounding sexual health has often been attributed to the lack of holistic training received in human sexuality. The public often perceives the therapists as "experts" in their discipline, but in reality, the scope of knowledge can sometimes be absent from the psychologists' training (Nathan, 1986; Sansone & Wiederman, 2000). The psychologist might possess less knowledge about sexual health and be more secretive about sex than the client. This lack of knowledge and secrecy surrounding sexual health is often attributed to the socialization to avoid taboo topics, such as sexuality, and to the minimal training received in the breadth of human sexuality (Miller & Byers, 2010; Reissing & Giulio, 2010; Wiederman & Sansone, 1999). Psychologists often feel under qualified in discussing sexual health concerns, which can affect their willingness to initiate conversations about sexual health (Harris & Hays, 2008; Reissing & Giulio, 2010). This discomfort on the part of the psychologist might also affect their ability to create a safe and non-threatening environment for the client to address other difficult issues (Harris & Hays, 2008). Presently, there have been no empirical studies conducted that identify factors that influence therapist perceptions about their sexual knowledge and strategies to increase their feelings of comfort with discussing sexual health. Future research would also benefit from the development of validated instruments that measure the various factors influencing sexual health discussions amongst psychologists and their clients.

Miller and Byers (2008) investigated clinical psychology graduate students' self-efficacy regarding assisting clients with sexual health issues and suggested that a lack of training in sexuality predicted less likelihood to ask about sex and less willingness to feel confidence to treat sexual issues. Due to the use of correlational methods, casual conclusions cannot be made from this study. The participants were also primarily Caucasian and from clinical psychology

programs. Therefore, the current study might not generalize to diverse populations or to individuals in other applied psychology programs. Regardless of the limitations, the results might be considered exploratory to suggest that psychologists may experience a lack of confidence and training that could otherwise support their sexual health self-efficacy. As a result, psychologists are opting to avoid issues related to sexual health or providing inaccurate or incomplete treatment interventions to clients. In more severe cases, psychologists are referring clients with sexual health issues to other professionals and potentially disrupting the therapeutic relationship (Miller & Byers, 2009). Regardless, all of these behaviors may warrant unethical behaviors on the part of the psychologist.

Self-confidence and extended support can positively affect a psychologist's desire to inquire about sexual health concerns of their clients. As expected, psychologists who are self-confident in their sexual health knowledge, and that receive supervision regarding sexuality, are more open to discussing sexual topics more frequently with their clients (Hanzlick & Gaubatz, 2012; Traeen & Schaller, 2013). The mere increase in knowledge and supervision concerning sexuality can have an impact on the likelihood of conversations about the subject of sexual health. Thus, psychologists' willingness to initiate sensitive topics, such as sexuality, may act as a model for future conversations. Additionally, researchers have suggested that framing sexual health on a continuum and expanding the current understanding and focus of sexual health from a holistic perspective might assist with psychologist knowledge (Burnes, Singh, & Witherspoon, 2017a; Cruz, Greenwald, & Sandil, 2017; Hargons, Mosley, & Steven-Watkins, 2017; Mosher, 2017). Currently, little is also known about the identification of factors that effectively increase a clinicians' comfort with sexual health. The need for further training to increase psychologists' confidence, and willingness to discuss sexual health, is known. However, little has been

incorporated into the graduate training programs to address the issue (Campos, Brasfield & Kelly, 1989; Nathan, 1986).

Research has suggested that psychologists lack the sufficient preparation to be competent in addressing sexual health issues (Burnes, Singh, & Witherspoon, 2017; Campos, Brasfield & Kelly, 1989; Cruz, Greenwald, & Sandil, 2017; Nathan, 1986). Although the current literature suggested lacks an empirical foundation, the authors provide the framework for exploratory avenues for considering the current trend of sexual health training for psychologists. The lack of empirical literature surrounding this topic further highlights the needs for further growth within this area of research. The construct of sexual health is also often overlooked and underrepresented in graduate training programs. Psychologists are often unknowledgeable regarding central topics in sexual health that can be imperative in the treatment of their clients. For example, topics of sexual health such as healthy sexual functioning, variations of sexual desires and fantasies, and the differences that exist across sexes are often left untaught in training courses (Burnes, Singh, & Witherspoon, 2017; Miller & Byers, 2008; Mosher, 2017; Widerman & Sansone, 1999). Instead, the limited sexual health within graduate training is framed through a medicalized lens that perpetuates the focus of a sex-negative health discourse that emphasizes disease prevention and risk aspects of sexuality (Arakawa, Flanders, Hatfield, & Heck, 2013; Hargons, Mosley, & Steven-Watkins, 2017; Lewis, 2004). Therefore, psychologists are provided with highlights of preventive sexual health education but are not supported in the acquisition of their knowledge and understanding of a healthy sexual discourse. According to the competency guidelines of the ethics code, psychologists are then expected to gain competency through obtaining training where their competency lacks (APA, 2010). However, the complexity and taboo nature of the construct of sexual health can often be overwhelming to

psychologists. They can also struggle to identify appropriate resources that can be helpful in their search for increased general knowledge and treatment interventions for sexual health (Hamberger et al., 2004; Miller & Byers, 2009). The failure of the field to provide clinicians with appropriate training in graduate school programs further perpetuates the lack of dialogue surrounding the area of human sexuality. As a result, ethical implications can arise regarding the competency of psychologists in sexual health.

Graduate training programs have continuously failed to address a range of sexual health topics within their training curriculum and have often placed the responsibility to build competency in sexual health topics upon the student (Miller & Byers, 2008). For example, Campos, Brasfield and Kelly (1989) identified that one third of graduate training programs offered courses related to human sexuality while the majority of the programs did not provide any training in this area. For the programs that did offer course opportunities, the authors were unclear as to the human sexuality content covered within those classes. They also were unclear as to the extent that sexual health concerns were addressed within the material. Therefore, the courses offered might not have explored information that would deem a psychologist competent within the concentration of sexuality. Similarly, Reissing and Giulio (2010) surveyed a group of practicing clinical psychologists and found that the majority of the participants indicated that they had not received graduate or undergraduate coursework or training experience in sexual health content. Similar to the previous study, the nature and degree of training offered were not identified from the programs. In addition, psychologists that chose not to respond to this survey might have experienced a different training atmosphere. The use of solely Canadian participants was also considered to potentially pose limitations with generalizability to other geographical areas. Regardless of these limitations, if necessary, the students were then suggested to have

gained supplemental training from resources outside of the department. In the late 1990's the push for extended research and discussion focused on human sexuality in graduate training programs is still present. For example, Widemen and Sansone (1999) surveyed training directors of doctoral programs and doctoral internships and found that a substantial proportion of the programs failed to offer an entire course on a sexual health topic and more than one third did not provide any coverage on healthy sexual functioning. Further clarification as to the type of training offered within these settings is also currently unknown. As not all of the eligible programs responded to their survey, it is possible that further limitations in training might exist. The lenient criteria for determining sexual health training within programs also poses concerns for how graduate programs are defining sexual health training. Lastly, the extent to which students actually participate in the training across the programs is unknown.

Fast-forward to the twenty-first century and the experiences of psychology graduate students appear to remain the same. The lack of momentum in the movement to further sexuality education in graduate programs continues to perpetuate a void in training within graduate programs. Miller and Byers (2008) highlighted a lack of sex education within clinical psychology programs and reported that less than half the students received didactic training surrounding healthy sexual functioning, relational issues related to sexuality, and contraception. Further, a majority of the students reported a lack of observation opportunities of a clinician addressing an issue related to sexuality. Clarification of the type of sexual health training received was not discussed within this literature. Given that research has shown observational learning to be a highly effective tool, this would suggest that graduate programs are not dedicated to providing their students with the most effective training in sexuality (Hudson, 2007). Miller and Byers (2010) continued to expand upon the lack of depth and breadth of

sexuality training in graduate school training programs. They found, that while nearly all clinical and counseling psychology students in the study had received some form of training in sexual health, the training was limited and was not representative of the work that might arise with clients. Furthermore, the students reported a lack of emphasis on gaining competency in healthy sexuality and instead were educated primarily on sexual dysfunctions and risks associated with sexual health. The students also reported a lack of consideration for client characteristics (i.e. SES, race, and gender) in the training received, which could affect the experiences of a client. Although the instruments used for this study were primarily created for this study, the implications suggest the need for further exploration of graduate training in sexual health topics. All of these implications pose questions for the content and nature of training that graduate programs are labeling as effective training opportunities in sexuality.

Students have used various sources outside of graduate training to receive knowledge and experience in sexual health. Common forums that students have used to extend their competency in sexual health have included consultation, workshops, practicum rotations, and continuing education. However, little is known about their effectiveness in building competency in sexuality. Few studies have shown that continuing education may be an effective way for psychologists to gain knowledge, intervention skills, and confidence in treating clients' sexual health concerns (Hamberger et al., 2004; Miller & Byers, 2009). The research that has been conducted in continuing education has been topic-specific and has shown to be beneficial for the specific sexual health topics explored. Miller and Byers (2009) explored continuing education in sexuality and found that the majority of continuing education was achieved through consultation or independent reading of sexuality issues. The authors also highlighted the noticeable lack of continued education in observational experiences. Although some researchers have evaluated

the impact of continuing education on certain topics, the overall amount and nature of the extended education that is needed to meet competency in sexuality is still unknown. This, in conjunction with the lack of graduate training, highlights the lack of sufficient preparation prevalent amongst psychologists in sexual health related issues.

This section discussed the current trend of sexual health training within graduate programs. The literature reviewed in this section suggested a paucity of sexual health training in graduate programs. Implications for limited graduate training in sexual health was also acknowledged.

Sex-Positive Framework

This section introduces literature that defines the complexity of a sex-positive framework. Specific values are acknowledged and how those values are congruent with a sex-positive framework is discussed. Further, this section discusses how the values of a sex-positive framework coincide with values of the field of psychology.

The sex-positive movement has fostered a holistic and comprehensive view of sexual health (Burnes, Singh, & Witherspoon, 2017; Hargons, Mosley, & Steven-Watkins, 2017; Mosher, 2017). The movement to de-pathologize sexual health emerged as a response to the societal repression of individual choice to experience one's own sexuality. Particularly this movement responded to heteronormative and conservative ideologies of sex that encouraged a dichotomy of "good" versus "bad" sexuality (Duggin & Hunter, 1995; Fahs, 2014; Glick, 2000; Rubin, 1993). Sex positivity has been defined as the belief that encourages all consensual expressions of sexual health and highlights the importance of individual meaning for one's sexuality (Kimmes, Mallory, Cameron, & Kose, 2015). As a theoretical framework, sex positivity acknowledges pleasure, freedom, and diversity. The sex positive framework has been

developed with eight dimensions: (a) “positive” refers to strengths, wellbeing, and happiness; (b) individual sexuality is unique and multifaceted; (c) positive sexuality embraces multiple ways of knowing; (d) positive sexuality reflects professional ethics; (e) positive sexuality promotes open, honest communication; (f) positive sexuality is humanizing; (g) positive sexuality encourages peacemaking; (h) positive sexuality is applicable across all social structures (Hargons, Mosley, & Steven-Watkins, 2017; Williams, Thomas, Prior, & Walters, 2015). Supporters of a sex-positive framework have highlighted the need for a dialogue of sexual freedom that emphasizes the presence of diverse, expansive sexual expressions.

Professional entities have also acknowledged a shift in the understanding of sexual health. Attempts to define and promote sexual health in the public eye have been primarily influenced by the definition developed by the World Health Organization (WHO). Over the course of decades, sexual health influenced the general definition of health to highlight that health extends beyond the absence of disease to also include a subjective experience of well-being (Edwards & Coleman, 2004). Giami (2002) suggested that various historical and political events have aided in the expanding definition of sexual health that has since evolved to include a focus on mental health, responsibility, and the importance of human rights. Sexual health is currently defined by the WHO (2006) 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.” This definition, similar to the ideologies of sex positivity, elaborates on the need for the understanding of sexual health to

be inclusive of sexual knowledge and the freedom of individual sexual pleasure. Further, the definition affirms the need for inclusive sexual education and an emphasis on the role of individual values, behaviors, and cultures that shapes an individual's sexual health (WHO, 1975).

A primary aspect of the sex-positive framework and movement is the value of the education of sexual knowledge. Sex positivists value a comprehensive focus of sex education that fosters knowledge beyond topics such as sexually transmitted diseases and birth control to topics related to sexual pleasure and fantasies and alternative families (Edwards & Coleman, 2004; Irvine, 2002). This interest has also been shown to be relevant to psychologists who are encouraging a similar comprehensive framework of sexual health knowledge be utilized within their profession (Burnes, Singh, & Witherspoon, 2017; Cruz, Greenwald, & Sandil, 2017; Hargons, Mosley, & Steven-Watkins, 2017; Mosher, 2017). Psychologists are working to gain a more positive relationship with sex within their discourse by suggesting that psychologists are incorporate a comprehensive understanding of sexual health into their framework. Further expansion of psychologist knowledge of sexual health would align with the suggested competency standards of interventions that require knowledge of evidence-based practices and individual and cultural diversity that promotes awareness of the needs of diverse groups (Fouad et al., 2009). Burnes, Singh, & Witherspoon (2017a) suggested that utilizing a sex-positive framework would aid psychologists in creating a continuum of sexual attitudes that can encourage clients to expand their sexual identities and functions of their sexual health. For example, psychologists practicing from a sex-positive approach possess knowledge outside of general information related to sexual orientation and expand their scope to issues related to topics such as polyamory or sexual fantasies. Specifically, Mosher (2017) suggested that

psychologists could add to their current breadth of knowledge by acquiring training related to topics such as body-positive sexuality, relationship-positive sexuality, kink-positive sexuality, and eroto-positive sexuality. Their inclusive knowledge and self-awareness of their own biases would aid the psychologist in normalizing client sexual health needs and avoid exacerbating culturally sanctioned stigmas related to their experiences (Kleinplatz, 2006). Additionally, their congruent values related to multiculturalism would incorporate a broader focus to expand to individuals with various statuses and backgrounds (Iantaffi, 2012; Sloane, 2014; Syme et al., 2013).

Self-exploration is another prominent value represented by psychologists that is congruent to a sex-positive framework. Competency guidelines used by psychology training programs highlights the importance of engaging in reflective practice and self-awareness. Psychologists who are competent in reflective practices monitor and evaluate their personal values, attitudes and beliefs and seek to resolve any issues that might interfere with their professionalism (Fouad et al., 2009). Cruz, Greenwald, & Sandhil (2017) suggested that exploration of personal attitudes and beliefs is a necessary component for a sex-positive framework. Exploration of one's own personal views of sex and sexual health that have been shaped by cultural messages can influence their professional work and can be highly problematic if not addressed. Burnes, Singh, & Witherspoon (2017a) suggested that through this self-explorative process, psychologists can become aware of, and counteract, erotophobic messages that might influence their treatment with clients. Erotophobia has been defined as. "...the irrational reaction to the erotic which makes individuals and society vulnerable to social control (Patton, 1985, p. 103)." Through the socialization of erotophobic messages, individuals can

develop shameful attitudes about sex and sexual health that can have a negative impact on one's interactions with other and their own personal resilience (Wright & Bae, 2016).

Current research suggests that psychologists often handle value conflicts by using strategies such as referring clients or consulting with a colleague or supervisor. However, the research also suggested that 40% of clinicians' preference was to refer clients when they encounter personally uncomfortable clinical situations such as those related to sexual health concerns (Ford & Hendrick, 2003). Researchers have suggested that referrals to a sex therapist or other professional can send messages to the client that the psychologist is uncomfortable discussing their sexual health. Further, this fails to adhere to ethical standards that requires professional psychologists to assist clients unless their needs are outside of the psychologists' scope of practice (Cruz, Greenwald, & Sandhil, 2017; Regas, 2011). Instead, referrals for sexual health related needs have been suggested to be appropriate for specific treatments related to sexual addiction, certain sexual disorders, and behavioral interventions related to sexual disorders (Binik & Meana, 2009; Cruz, Greenwald, & Sandhil, 2017). A sex-positive approach encourages the exploration of one's understanding of these erotophobic messages and engages the individual in a process of seeking additional knowledge to understand the client's viewpoint (Burnes, Singh, & Witherspoon, 2017b).

Limited attention has been directed to psychology's overall focus on sexual health research. The competency of research and evaluation encourages psychologists to engage in systematic efforts to increase the field's knowledge bases through the implementation of productive research (Fouad et al., 2009). However, minimal effort has been present in the field of psychology regarding a holistic and comprehensive view of sexual health in research.

Hargons, Mosley, & Witherspoon (2017) conducted a content analysis in specific counseling

journals over a 61-year period to investigate the nature of current sexuality research. The authors suggested that research on sexual orientation, sexual identity, and sexual minorities was amongst the most highly researched areas of sexual health. Further, only 5% of the articles used a sex-positive approach; quantitative and conceptual articles were the primary methodology used; and minimal focus was given to diverse populations. This highlights the limited scope of research that is being utilized to inform professional psychologists of their sexual health knowledge.

A similar study was conducted by Arakawa, Flanders, Hatfield, & Heck (2013) that explored the sexual health content of medical and sexuality journals and found that the vast majority of the research focused on distress related to sexual health. Further, Lewis (2004) highlighted that sexual health research related to minority populations is often focused primarily on preventative sexual health practices and underemphasizes a positive sexual discourse. Failure to provide a breadth of literature on multicultural populations' sexual health experiences can limit a clinicians' understanding. The American Psychological Association has contributed to research on sexual health by providing its professionals with professional practice guidelines with particular populations. Specific topics that have been touched on by APA include sexual orientation (APA, 2011); transgender and gender nonconforming people (APA, 2015); prevention of sexual abuse, sexual assault, and sex trafficking (Taskforce on Trafficking of Women and Girls, 2014); and sexualization of women and girls (APA, 2010). Although these are important contributions to the field, the overall focuses of the guidelines are framed through a disease prevention and a risk management framework that fails to frame sexual health toward a more positive discourse. These research studies highlight the lack of a comprehensive analysis and inclusive research methodologies to explore the nature of sexual health.

This section discussed the defining components of a sex-positive framework. Attention was given to specific values that define a sex-positive framework. The utility of this framework in the field of psychology was also highlighted.

Sex-Positive Framework in Psychology Research

This section will discuss how a sex-positive framework provides a broader lens to view sexual health. Research that has referenced the utility of a sex-positive framework are explored. This section will also discuss the sparsity of sex-positive literature in the field of psychology.

Few studies have addressed sexual health research through a sex-positive framework in the field of psychology. Research that is informed by sex-positive tenants differs from research that is focused from a risk and prevention framework. Harden (2014) suggested that a sex-positive framework views sexual health as a normative process of human development that can vary for each individual and across contexts. The framework emphasizes the exploration of an individual's pleasure and wellbeing in relation to their sexual health. Researchers who are positioned from a sex-positive framework are considerate of emotional, cognitive, and relational elements of sexual health. Although there is a lack of empirical research, sex-positive researchers have started to initiate a call to action by suggesting potential guidelines for the incorporation of this framework into research. These concepts were present in a study conducted by Kimmes, Mallory, Cameron, & Kose (2015) that incorporated a sex-positive framework in their investigation of the utility of mindfulness meditation for anxiety-related sexual dysfunctions. The researchers suggested that a sex-positive mindset can orient the therapist to acknowledging their clients' unique sexual health needs. Similarly, Spencer & Vencil (2017) recommended the incorporation of a sex-positive approach into a group therapy curriculum for transfeminine adults. The framework would encourage an acceptance of all individuals across

the gender spectrum and for the clients to explore their sexual health through an empowerment and pleasure-based focus. The primary goal of the group would be to provide therapeutic support for clients on the transfeminine spectrum and to increase their self-esteem, pleasure, and agency of their sexual identities and experiences. As referenced in these studies, sex-positive research seeks to examine the effects of systematic oppression on the experiences and knowledge of sexual health. Although suggestions have been made in support of this framework, minimal effort has been made to incorporate these ideologies into current psychological research trends (Burnes, Singh, & Witherspoon, 2017a; Campos, Brasfield, & Kelly, 1989; Miller & Byers, 2010). The current literature fails to provide research that has used valid and reliable measures to identify the effectiveness of incorporating a sex-positive framework. Further, the referenced studies would have benefited from using a consistent definition of sex-positivity. The field would therefore benefit from further research to empirically represent the usefulness of a sex-positive framework.

This section discussed the use of a sex-positive framework in psychology literature. Examples of exploratory research was highlighted to acknowledge the infancy of sex-positive research. This section also highlighted methodological issues that are currently present in sex-positive research.

Counseling Psychology and Sex-Positive Framework

This section discusses core values that are representative of counseling psychologists. The connection of counseling psychology values to a sex-positive framework are further discussed.

Counseling psychologists' core values are represented within their professional practice. Counseling psychologists are focused on engaging in research and practice that is sensitive to the

needs of diverse populations. Their inquiries are committed to the development of research that expands on the professional knowledge of the field and that integrates individuals of varying demographics. They actively work to promote social justice values and to prevent further oppression within marginalized groups (Ivey & Collins, 2003). A social justice perspective emphasizes issues of societal concerns related to issues of equity, self-determination, interdependence, and social responsibility (Vera & Speight, 2003p. 254). Additionally, they actively seek to embrace a strengths-based perspective within their clinical work and through their research. Their efforts serve to highlight and enhance the many strengths of people in order to build resiliency (Linley, 2006; Lopez et al., 2006). The use of self-reflective practices is also a prominent value of a counseling psychologist. These tools require the individual to demonstrate a desire to explore their personal biases and attitudes and confront those that can impede their professional work (CCTP, ACCTA, & SCP, 2009; Motulsky, Gere, Saleem., & Trantham, 2014). Counseling psychologists employ these values in the development of skills and knowledge that aid them in working effectively with individuals from diverse backgrounds.

Researchers have recently started to highlight the presence of counseling psychologists' values within a sex-positive framework (Burnes, Singh, & Witherspoon, 2017a; Burnes, Singh & Witherspoon, 2017b; Cruz, Greenwald, & Sandhil, 2017; Mosher, 2017). Cruz, Greenwald, & Witherspoon (2017) suggested that incorporating a sex-positive framework into the training of counseling psychologists would provide an extension to their emphasis on diversity. These authors suggested a framework for the integration of sex-positive ideologies into the practices currently used by counseling psychologists. The use of self-reflective practices about one's personal beliefs and attitudes is primary before exploring a client's sexual health. Competent practice requires an ongoing commitment to exploring one's individual biases and prejudices and

can hinder the therapeutic relationship if not adequately addressed. This also requires the clinician to integrate a multicultural and social justice awareness into their process in an effort to approach clients through a culturally sensitive lens. Counseling psychologists are also recommended to develop sex-positive knowledge and comfort about sexual health.

Psychologists have been encouraged to maintain a basic knowledge, at minimum, about empirically supported treatments for sexual disorders and the various contexts that can influence these disorders (Nathan, 1986). A sex-positive framework would further encourage the psychologist to gain knowledge on the variations of sexual functioning, desires, and fantasies across cultural contexts (Mosher, 2017; Popovic, 2006).

The authors encourage counseling psychologists to explore their level of comfort in proactively initiating a conversation about sex or sexuality with clients. Suggestions have been made that psychologists can begin this process by integrating sexual health related topics into the initial assessment or intake. When appropriate, psychologists are encouraged to invite their clients to engage in conversations about their sexual health and be mindful of presenting with a nonjudgmental attitude. Psychologists can also incorporate assessment tools and match the client's sexual language to increase comfortability of the topic. Lastly, scholars suggest that psychologists would benefit from understanding when discussing a client's sexual health might be detrimental to their progress and when the client's sexual health needs are outside of the clinicians' scope of practice (Burnes, Singh, & Witherspoon, 2017a; Cruz, Greenwald, & Witherspoon, 2017; Mosher, 2017). Researchers in support of incorporating a sex-positive framework have suggested additional components such as incorporating a strengths-based approach; understanding the individual sexual health needs of a client; welcoming a range of research approaches to this topic; emphasizing a sex-positive framework's connection to ethics

of the field; and providing a peaceful, accepting atmosphere within the therapeutic relationship and community of professionals (Williams, Thomas, Prior, & Walters, 2015). Although empirical research does not currently exist to support these suggestions, authors have identified the before mentioned suggestions through exploratory methods. Therefore, the literature could be further expanded by the development of instruments to measure the validity of these claims. As the literature currently stands, suggestions have been made for counseling psychologists to incorporate sex-positive values into their current framework to provide clients with a sensitive space to discuss their sexual health needs.

This section discussed suggestions that have been made through exploratory research methods about the utility of a sex-positive framework in psychology. This section also highlighted how the limited methodologies used to support these claims can impact their utility for counseling psychologists.

Summary

The literature review suggests that further research is warranted regarding the concern about psychologists' competency to assist clients with their sexual health. Additionally, further concern regarding the current sexual health framework that is being utilized to educate psychologists has been noted to be of concern in recent research (Burnes, Singh, & Witherspoon, 2017; Cruz, Greenwald, & Sandil, 2017; Hargons, Mosley, & Steven-Watkins, 2017; Mosher, 2017). This literature review also suggests that current sexual health training for psychologists has been framed through a medicalized lens that fails to encompass a comprehensive, holistic understanding of sexual health. Further exploration regarding psychologists' experiences in competently treating client sexual health needs through a sex-positive framework that encourages an open exploration sexual health is needed. Additionally, the role graduate training

plays in counseling psychologists' understanding of sexual health through a sex-positive framework needs to be further explored.

CHAPTER III: METHODOLOGY

Overview

This chapter will present the methods that were employed in the study. First, the research questions will be identified, followed by a description of the research paradigm. The next section will describe the participants in the study and how they were recruited. The following section will describe the research auditor and their training. The participants in the study will then be described. The next section will describe the data collection procedures, including participant recruitment and the interview protocol. Researcher biases and expectations will then be explored. Finally, the procedures for preparing and analyzing the data will be described, followed by a chapter summary.

Research Questions

1. What have counseling psychologists experienced in assisting clients with their sexual health?
 - a. How do counseling psychologists feel about their competency in sexual health to assist clients?
 - b. What meaning do counseling psychologists apply to a sex-positive framework?
 - c. What experiences have counseling psychologists had with sexual health training within their graduate programs and outside of their programs?
 - d. What role do counseling psychology values play in the experiences of counseling psychologists in assisting clients with their sexual health?
 - e. What role does the counseling psychologists' personal values play in assisting clients with their sexual health?

Research Design

Qualitative methodologies and a phenomenological research design were used to explore the research questions. Qualitative methodologies suggest that the sociocultural aspects of the world are uniquely experienced, interpreted and are influenced by the presence of contextual factors (Heppner, Wampold, & Kivlighan, 2008). According to this methodological structure, objective reality is never completely understood due to the multiple realities that can be perceived from multiple perspectives. Given the complexity and diversity of human experiences, qualitative research aims to explore the holistic experiences of individuals while attempting to avoid reductionistic boundaries. Qualitative inquiry seeks to understand the lived experiences of particular situations and/or phenomenon. The type of qualitative methodological approach that is selected depends on various factors: of the purposes of the researcher; his/her specific talents; but most importantly, the nature of the research questions and data collected. The method selected is used a general guideline that is then modified by the researcher to meet the particular needs of the study (Hein & Austin, 2001).

The phenomenological method is one such qualitative approach that can be adapted to the characteristics of the phenomenon being investigated. A phenomenological inquiry has been defined as "...an attempt to deal with inner experiences un-probed in everyday life (Merriam, 2002, p. 7)." The basic concepts of consciousness, intentionality, and intuition guide the phenomenological process. The concept of consciousness refers to the awareness of the system that consists of the self, world, and others. This is an awareness of how they are precisely presented without any addition or deletion of their being. Intentionality is the "fundamental process of consciousness" that is always directed or related to an object. Lastly, intuition is viewed as the starting place in deriving knowledge of human experience that is free of

impressions and natural attitude (Moustakas, 1994;Wertz, 2005). Through the interconnectedness of its core concepts, the researcher engages in an undetermined process of phenomenological studies.

The phenomenological approach focuses on identifying the essence of a common theme among participants in order to describe a universal phenomenon (Creswall & Path, 2018). Husserl believed a sharp contrast exists between facts and essence, between the real and non-real. An essence is described as the inner essential nature of an object that becomes what is known of the object. In order to extract the essence of one's experience, the phenomenon has to be studied as it has actually taken place for that individual. The essence can then be described, as the description shows the researcher the lived quality and significance of the experience through a richer meaning (Groenewald, 2004). Phenomenological research is interested in identifying and describing "what" the participants have experienced and "how" they have experienced a specific phenomenon (Moustakas, 1994). A person's conscious experience becomes influenced and interdependent on various processes such as one's spatial surroundings, temporal processes, sensory perception processes, socialization, and meaning making processes (Wertz, 2005). The essence emerges from rich, contextual descriptions from the participants and is usually obtained through individual interviews (Creswall, 1998). The researcher then reflects to identify meaning themes that assists in building a general description of the phenomenon.

The relationship between the researcher and participants is central to a phenomenological study. This method uses a holistic understanding of an experience that is obtained through understanding the multivariant relationships and subjective meaning making processes. (Colaizzi, 1978). A specific phenomenological approach, transcendental phenomenology, was used to draw on the phenomenon. In this approach, the researchers collect data from several

persons that have experienced the phenomenon and actively engages in self-reflective processes. The data is organized into meaning units and then meticulously reflected on to provide the readers with a thorough description as close to fidelity of the participants' experiences with the phenomenon (Wertz et al., 2011). A textural description of the experiences; identification of what the participants have experienced, a structural description; or how the participants have experienced the phenomenon, and a combination of the two focuses is explored to discuss a universal essence of the phenomenon (Creswall & Path, 2018). In this study, the essence and general structural description was focused on the experiences of counseling psychologists in assisting clients with sexual health and on the meanings made about the use of a sex-positive framework to assist clients with these needs.

The research process also becomes a reflective process for the researchers involved in the process. Husserl introduced the concept of epoche, also known as bracketing, that encourages the researcher to "stay away or abstain" from their judgments and biases. Phenomenologists have highlighted the importance of "bracketing", which describes the process of the researcher gaining awareness of their own implicit assumptions and setting them aside to avoid interference with the research (Morrow, 2005). The process serves to identify the researcher's personal experiences with the phenomenon, so their assumptions are less influential in the research process. This becomes a process of identification that suspends naturally occurring thoughts about a phenomenon to allow events and objects to enter anew into consciousness as if experienced again for the first time. The process of bracketing is an intentional act that requires researchers to continuously engage in the process throughout the re-experience of the phenomenon (Moustakas, 1994).

In regard to the current study, this required the researchers to explore their personal assumptions about sexual health and consciously refrain from allowing those assumptions to interfere with the research process. In contrast to positivists, phenomenologists believe that a researcher's presumptions cannot be detached from their research and instead should be explored (Hammersley, 2000). Qualitative researchers do this by approaching their research reflexively in which they utilize self-reflective processes throughout the process such as using a self-reflective journal to record their reactions or consulting with a research team member for potential alternative explanations (Wertz & Hansen, 2005). Phenomenological researchers also aim to represent the client's experiences by using specific strategies to gain a clear understanding of the participants' reality such as asking for clarification from the participants and taking the stance of naïve inquirer (Wertz & Hansen, 2005). The incorporation of critical incidents has also been suggested to be useful in extending the researcher's understanding of the phenomenon. The use of the critical incident technique allows for an examination of a participants' direct involvement in an incident and provides the opportunity for a deeper discussion of its critical nature (Halquist & Musanti, 2010). The researchers use of self-reflective processes aids in the unfolding and understanding of the phenomenon through an objective lens.

Positionality of the Researcher

A phenomenological framework requires an active engagement from the researchers in exploring their influences on the research process. The epoche has been recognized in phenomenological research as the researchers' awareness from being influenced by scientific or natural theories, explanations, or hypotheses related to the phenomenon being studied. Therefore, researchers approach the phenomenon with an empathic attitude and by suspending prior beliefs and experiences with the phenomenon. The researchers set aside, in brackets, their

personal experiences with the phenomenon or any preexisting theories or assumptions about the phenomenon. The goal of this process is to assist the researcher in returning to a natural attitude about the phenomenon (Wertz & Hansen, 2005). As a counseling psychologist in training with a background in feminist studies, I have experience in assisting clients with their sexual health needs within my clinical and research endeavors. The bracketing of my personal experiences functioned as a way acknowledge the potential influence of my biases in the data analysis process. This process allows the reader to understand how I have approached the topic of counseling psychologist competency in sexual health from a natural attitude. The presence of a natural attitude will be crucial in order to observe the essence of the participants' experiences. The following is a bracketing of my personal pre-existing presumptions and biases related to sexual health competency of counseling psychologists:

1. Sexual health is a part of the lived experience of clients that are assisted by psychologists.
2. The sexual health experiences of psychologists are influential in their professional work.
3. Psychologists feel uncomfortable discussing sexual health with clients.
4. Psychologists often do not engage in self-reflective processes about sexual health.
5. Psychologists' understanding of sexual health is influenced by psychosocial, contextual, and value laden factors.
6. The psychologists' personal biases about sexual health impacts their professional work with clients who are navigating their sexual health.
7. Psychologists are aware of their personal biases about sexual health and can more intentionally facilitate the process of assisting clients with their sexual health needs.
8. Psychologists are not adequately trained in sexual health knowledge and interventions.

9. Psychologists do not feel that their graduate programs provide adequate sexual health training for them to assist clients.
10. There is value to the field of counseling psychology in learning about sexual health such as increasing psychologists' level of comfort and willingness to discuss the topic.

Research Auditor and Training

The research auditor had a doctorate degree in counseling psychology with a background in human sexuality. She was selected based on convenience and her interest in exploring social justice research related to gender and human sexuality. The research auditor was encouraged to engage in self-reflective processes throughout the duration of the research process. Patton (2015) defines this as the process of reflexivity that emphasizes, "...the importance of deep introspection, political consciousness, cultural awareness, and ownership of one's perspective." Reflexivity required the research auditor and principal investigator to consider their interpretations and how they have been influenced by contextual and environmental processes. This was done by encouraging the research auditor and principal investigator to keep memos about their reactions to the data. The memos were shared amongst the research team and conversations about their responses were used to explore potential biases that might interrupt the data coding process.

Participants

Participants in this study are licensed counseling psychologists that have a history of clinical practice. Two types of purposeful sampling strategies were used for this study, criterion sampling and snowball sampling. Criterion sampling was used to specifically draw from a criterion sampling strategy to seek participants that met certain criteria and to assist with quality assurance. Participants who were eligible to participate were licensed psychologists that

specifically identified as a counseling psychologist and had experience working with client sexual health needs. Snowball sampling is a technique that identifies participants of interest from sampling people that know others who have experienced the phenomenon (Patton, 2002). Participants were not expected to have prior knowledge of a sex-positive framework to participate in this study. Participants who are affiliated with other branches of psychology (i.e. clinical, industrial organizational, etc.) were excluded from participation due to the study's focus of the connection of a sex-positive framework to counseling psychology values. Individuals were selected from this group to ensure that all members identified with values specific of counseling psychologists and to ensure that all participants had experienced the phenomenon being explored (Creswell & Path, 2018).

Patton (2002) suggests that formal rules for participant size are not necessary for qualitative inquiry. Instead, Patton (2002) suggested that sample size depends on the researcher's knowledge of the phenomenon, credibility of the size, and the available time and resources. For this study, the researcher sought to interview 10-15 participants, but was only able to gain consent from 5 participants to participate in the in-depth interview. The sample consisted of participants that ranged in age, cultural background, professional setting of practice, practice interest, and geographical location. Pseudonyms were selected for the participants to maintain their anonymity and confidentiality to their experiences. These were selected by searching popular generation appropriate baby names and selecting a pseudonym that was also consistent with their ethnicity.

Recruitment Process

A mixture of snowball, convenience, and purposeful sampling was used to collect participants (Patton, 2015). A recruitment email was initiated twice through an email addressed

to all counseling psychologists on the APA, Division 17 list serve (Appendix A). This yielded minimal interest in participation and the use of convenience and snowball sampling was used to obtain the remaining participants. In an attempt to obtain additional participants, an addendum was approved to the original study to contact faculty of APA accredited counseling programs via email. However, this did not yield additional participants for the study and recruitment was stopped. The participants were informed that the purpose of the study is to gain an understanding of counseling psychologists' experiences in assisting clients with their sexual health through a sex-positive framework. They were also informed that an initial prompt about their experiences and demographic information was expected to be completed prior to the interview, that the length of the interview would be about one hour in duration, and that a potential follow-up interview might be used if additional clarifying information was needed. The participants were informed that there was no compensation for participation in this research study.

Participants who were interested in participating were encouraged to contact the lead investigator via email or telephone to identify a time and method for the completion of the interview or for additional questions about the study. Interested participants were introduced to the study procedures and qualified participants were then scheduled for an interview. The interested participants were sent a copy of the informed consent to be signed and were requested to return the signed document to the lead investigator prior to scheduling their interview (Appendix B). The participants and lead investigator then identified a date, time, and method for completion of the interview. Participants were asked to complete a paradigm case questionnaire and demographic information prior to their interview (Appendix C & Appendix D). These documents were completed on Qualtrics from a link provided to the participants in their email.

They were requested to complete the documents at least two days prior to their scheduled interview. Participants who did not meet criteria to participate in the study were thanked for their interest in the study and encouraged to seek participation in future research opportunities.

Data Collection

The participants were offered to complete the interview in-person or via video (Skype, Zoom, etc.) interview. All of the participants of this study chose to complete the interview via video. Participants were asked to complete a paradigm case questionnaire and demographic questionnaire prior to their interview. The participants were requested to return the documents to the lead investigator via email at least two days prior to their scheduled interview. The paradigm case tool asked participants to write a brief description about a positive or negative experience they considered significant or memorable in relation to assisting clients with their sexual health. This tool served as a preface for generating reflective thoughts that lead into the interview process.

Interviews were conducted by the principal investigator and occurred in a confidential space such as a closed office. The interviewer verbally reviewed the interview procedure and informed consent with the participants. The participants were informed that the interview was recorded and that their participation could be waived at any point in the process. Participants provided verbal consent when they are ready to begin the interview. The interviewer asked the designated interview questions found in Appendix E. Questions were open-ended and focused on (a) counseling psychology values, (b) professional experiences with sexual health, (c) graduate training experiences in sexual health, and (d) value influences related to sexual health. A semi-structured interview format was used to allow for follow-up questions to responses from the structured interview questions. All interviews were recorded using an electronic audio

recording setting on the Zoom system and they lasted approximately 60 minutes. Participants were informed during the informed consent process as to how their interviews would be recorded based on the method of interview. Upon completion of the interview, the participants were thanked for their time and provided with contact information for the principal investigator. The participants were given the option to have their transcripts shared with them once they were transcribed.

Interview Transcripts

The participant interviews were all completed via Zoom on the following days:

- Michelle, Interview 1, 09/17/2018
- Donna, Interview 1, 10/01/2018
- Rachel, Interview 1, 12/10/2018
- Rebecca, Interview 1, 12/17/2018
- Sonia, Interview 1, 03/13/2019

Data Transcription

The principal investigator used a transcription program (Happy Scribe) to assist in transcribing the verbal interview responses for each participant. The principal investigator checked through each interview twice for accuracy following the use of the transcription program. Identifying information was removed and all interviews were transcribed using pseudonyms to protect for confidentiality. Audio recordings will be destroyed after the completion of the study. Transcriptions are stored on a locked computer in which access is only obtained by the principal investigator.

Data Coding and Analysis

The principal investigator used the paradigm case questionnaire to generate reflective thoughts and identify emerging themes present amongst all of the questionnaires about the investigated phenomenon. Data coding and analysis was completed following the outline of the data analysis spiral and considerations of general analytic procedures (Creswell & Path, 2018; Wertz et al., 2011). All of the steps in the process of the data analysis spiral are interrelated and require the use of analytic strategies to represent the data. The first step involved managing and organizing the data by creating an accessible file naming strategy to easily locate and analyze the stored data. This helped the principal investigator create a long-term filing plan that assisted the lead investigator in maintaining the data.

The next step required a complete immersion by the principal investigator of the experiences described by the participants. The principal investigator then read the participants' experiences and developed memos of the main ideas of the data. This required the researcher to read the transcriptions several times while taking notes and engaging in reflective thinking about the data. The principal investigator identified the "existential baseline" or background of the experiences for each participant (Wertz et al., 2011). This was a critical phase as the statements that are seen to illuminate the researched phenomenon are extracted or "isolated". The isolated units were carefully considered, and the redundant units were eliminated. The researcher considered the literal content; the number of times a unit was mentioned; and how the unit was mentioned. Further, the researcher also considered the actual meaning of seemingly similar units, as they might have differed in terms of weight or chronology (Groenewald, 2004). The use of writing memos in the margins of the was transcriptions is also used during this phase of the process. Memos have been defined as "...short phrases, ideas, or key concepts that occur to the reader

(Creswell & Path, 2018).” The use of memos assisted the principal investigator in thinking more critically about the essence of the data.

Next, the principal investigator independently described and coded the data into relevant themes or meaning units. Specifically, the principal investigator developed codes for each of the documents. The formation of the codes is a primary component of the qualitative process that aids the researcher in capturing the universal experiences of the participants. The researcher built detailed descriptions, applied codes, and developed themes from the data in order to provide an interpretation of the data. To code the data, the lead investigator read each sentence of the interview transcriptions and identified a theme. A relevant phrase or keyword that was expressed within the transcription sentence was used to identify potential themes. A descriptive coding technique provided labels for an inventory of the topics discussed throughout the interview (Saldana, 2009, p. 70). The themes were also grouped based on “what” the participants experienced (textural description) and “how” the experience happened (structural description).

The principal investigator created an inter-codal agreement for the research auditor to check the accuracy of the created themes (Appendix F). In the inter-codal agreement, the research auditor was provided with selected quotes from each of the transcripts and the initial themes developed by the principal investigator. The goal of the inter-codal agreement was for the research auditor to identify if the themes developed by the principal investigator matched to the participants’ quotes. If the research auditor did not feel the themes were relevant to the quotes, she was provided space to identify a new theme and the definition of the theme. The principal investigator and research auditor then discussed the identified themes from the inter-codal agreement, and a consensus was made of relevant themes amongst the team. A codebook was

created based on the agreed upon codes by the research team in order to establish boundaries for each code. The principal investigator then coded the remainder of the interviews using the established coding dictionary. Lastly, the research team clarified any further issues related to the coding process. The overall goal of coding was to identify a more complex organizational understanding of the data that could be broken into more specific categories (Saldana, 2009, p. 149).

The principal investigator engaged in an interpretative process of the data that was generated by the categorized data. This required the researcher to think abstractly about the data while engaging in a self-reflective process of challenging one's own personal biases about the data. During this part of the process, the investigator's own presumptions and meaning was suspended from entering into the essence of the participants' experiences. Feedback from the research auditor about the initial interpretation was used for accuracy and intentionality. For this study, the researcher linked the interpretation of the data to relevant literature about sexual health competency amongst psychologists. Lastly, the researcher provided a representation of the data through a structural overview to discuss the general themes that were consistent or inconsistent amongst participants' experiences with the phenomenon. A composite description of the phenomenon has been suggested to be useful for representing phenomenological data in which the data assessed will be used to discuss a universal essence of what the participants reported experiencing and how they have continued to experience the phenomenon.

Creditability

The creditability of qualitative research findings and interpretations are dependent upon careful attention to building trustworthiness. Trustworthiness focuses on the detail and quality of the study and the criteria that can be assessed to determine the genuineness of the research

process (Glesne, 2016). Lincoln & Guba (1985) suggest that careful attention to the researcher's time spent with the process is critical to building trustworthiness. The principal investigator was cognizant of the time spent interviewing and building sound relationships with the participants. The principal investigator's contact information was made available for participants for questions concerning the research process. Time spent with the data and interpretation process also assisted with building trustworthiness. The principal investigator wrote descriptively so that readers could understand the context of the interpretations from the voice of the participants. Additionally, triangulation procedures were used to connect multiple investigators together to analyze the data and its interpretations. The use of external sources, such as the research auditor, was also used to provide input and feedback into the research process, data analysis, and interpretations. This will aid in allowing the readers to gain an understanding as to how a conclusion was reached from multiple sources.

Further, the principal investigator actively reflected on her subjectivities and how they were both utilized throughout the process and monitored so not to influence the interview process or interpretation. Therefore, the principal investigator spent time independently exploring potential biases in order to engage in conversations about her responses with the dissertation committee. As Glesne (2016) suggested, the lead investigator also provided a paper trail by saving and organizing all of the research related documents relevant to this particular project. Items of this audit trail includes documents such as drafts of the interview questions or research proposal, copies of the interviews and their transcriptions, coding schemes and data analysis interpretation across the various sources, and any additional documents that were related to production of this project. Lastly, the principal investigator linked interpretations and conclusions about the data to relevant research pertaining to counseling psychologist competency

in sexual health to confirm that the inquiries addressed in this study have been previously acknowledged in the literature.

Summary

This chapter offered an overview of the methods used in the study. Specifically, this chapter highlighted the research questions, study design and framework, data coding and analysis procedures, and issues related to credibility and meaning formation. This study used a qualitative methodology framework stemming from a phenomenological research design to explore the lived experiences of counseling psychologists in assisting clients with sexual health needs through a sex-positive framework. Participants and the lead investigator are affiliated with the field of counseling psychology's values. Special attention was also given to the credibility of the research due to the principal investigator's connection to the topic.

CHAPTER IV: FINDINGS AND RESULTS

Overview

The purpose of this chapter is to present the results of the data collected. The goal of the study was to provide a description of the lived experiences of licensed counseling psychologists in addressing sexual health topics with clients. The following research questions framed the course of the study:

1. What have counseling psychologists experienced in assisting clients with their sexual health?
 - a. How do counseling psychologists feel about their competency in sexual health to assist clients?
 - b. What meaning do counseling psychologists apply to a sex-positive framework?
 - c. What experiences have counseling psychologists had with sexual health training within their graduate programs and outside of their programs?
 - d. What role do counseling psychology values play in the experiences of counseling psychologists in assisting clients with their sexual health?
 - e. What role does the counseling psychologists' personal values play in assisting clients with their sexual health?

Within this chapter, the reader is provided with demographic information of the participants, a discussion of the critical incident questionnaires, and a review of the major themes that emerged. Data analysis and reporting of results in phenomenological research requires the researcher to provide a textual description (“what” happened) and a structural description (“how”) the phenomenon was experienced by the group of participants (Creswell, 1998). The

reporting will occur during the discussion and meaning development of the major themes, using examples and statements from the participants to support the analysis. This study identified 10 superordinate themes that were present in most of the participants' accounts of their lived experience of the phenomenon. The 10 superordinate themes have been organized into the following: (1) Ability increased (2) Connection of counseling psychology values to sexual health (3) Sexual health competency (4) Sex-positive framework defined (5) Comfort increased (6) Sexual health conversations (7) Absence of training and supervision (8) Absence of continuing education (9) Educational suggestions (10) Relevance of personal identities and values. A brief overview of the themes and their connection to specific research questions will be reviewed later in this chapter (Table 2).

Demographics

This study consisted of five participants, each of whom completed one in-depth semi-structured interview. All participants identified as licensed counseling psychologists who had experience assisting clients with their sexual health. Demographic information for the participants is provided in Table 1 and summarized in this section. All of the participants were female with ages ranging between 34-64 years of age. Four of the participants identified their race/ethnicity as Caucasian/White and one participant identified as Asian Indian American. The participants obtained their master's and doctoral training from various universities across the country; University of Maryland, University of Maryland College Park, University of Tennessee, Lehigh University, and Washington State University. Their current location of practice also varied and consisted of Pennsylvania, California, and Guam. One participant reported that she is not actively seeing clients at this time. Their current professional settings consisted of academia,

private practice, military hospital, and rural pediatric integrated primary care. Participants had been licensed between 4 and 35 years.

Table 1: Participant Demographics

Participant Pseudonym	Age	Race/Ethnicity	Gender	Master's Training	Doctoral Training	Current State of Practice	# of Years as a Licensed Psychologist	Current Professional Work Setting
Michelle	40	Caucasian	Female	Northeastern University	Northeastern University	Not currently seeing clients	4 years	Academia
Donna	64	Caucasian/Irish Catholic	Female	Northeastern University	Northeastern University	Pennsylvania	35 years	Private Practice
Rachel	33	Caucasian	Female	N/A	Southern University	Guam	5 years	Military Hospital
Rebecca	37	Caucasian	Female	Northeastern University	Northeastern University	California	8 years	Private Practice/University Professor
Sonia	34	Asian Indian American	Female	Pacific Northwest University	Pacific Northwest University	Pennsylvania	4.5 years	Rural Pediatric Integrated Primary Care

Phenomenological Textual and Structural Description

In phenomenological research, the textual description produces the collective meaning of the participants' experiences (Kafle, 2011). The textual description for this study is a composite of what the participants' experienced in assisting clients with their sexual health. This description provides the reader with a vivid depiction of what the group experience as a whole, including what happened in specific situations and incidents. Additionally, a structural description was also developed from the data that provides the reader with an understanding about how the participants experienced the phenomenon. This phenomenological analysis provided a structural description of how the phenomenon of assisting clients with their sexual health needs was experienced by the counseling psychologists as a group. Revealing specific

beliefs, feelings, and attitudes about how counseling psychologists critically reflected on their experiences with assisting clients with their sexual health.

The participants in this study described how they experience assisting clients with their sexual health needs and issues that arise for them during these situations. Initially, participants were unsure of the relevancy of the topic to their professional lives but discussed their insight into its relevance as the interview progressed and their stories expanded. All of the participants discussed experiencing feelings of incompetence and a realization of inadequate graduate training and supervision in sexual health. Some of them identified specific situations they felt their incompetency and inadequate training influenced their ability to assist a client with their sexual health needs. The participants identified different steps they took to independently increase their competency and comfort in assisting clients with their sexual health. All of the participants identified the relevance of gaining competency in sexual health and identified specific educational opportunities that would help increase their competency in sexual health. The participants were also able to identify specific components of a sex-positive framework that were relevant to their counseling psychology values. Additionally, all of the participants felt their personal identities and values influenced their approach to assisting clients with their sexual health. The final step in the phenomenological data analysis is to present the composite structural and textual descriptions to develop a synthesis of meanings (Moustakas, 1994; Patton, 1990). The description or review of the “essence” of counseling psychologists’ assisting clients with their sexual health will encompass the major themes and explain the core of their experiences with the phenomenon.

Superordinate Themes

All of the interviews were individually analyzed, and emergent themes were identified to establish connections and patterns of meanings across all of the participants' stories. Efforts were made to illuminate common themes in participants' accounts and organized to reference the guiding questions established at the onset of the study. A general description of the superordinate themes that emerged is provided and exemplary quotes of the raw data that illuminate the themes are provided. There was a total of 10 superordinate themes that emerged from the participants stories, which will be reviewed below according to the guiding question they most closely addressed (Table 2). A brief overview of the themes is provided next, followed by a more in-depth individualized description of each theme.

Table 2: Superordinate themes by guiding questions

Guiding Question	Superordinate Themes
1. How do counseling psychologists feel about their competency in sexual health to assist clients?	a. Ability increased
2. What role do counseling psychology values play in the experiences of counseling psychologists in assisting clients with their sexual health?	b. Connection of counseling psychology values to sexual health
3. What meaning do counseling psychologists apply to a sex-positive framework?	c. Sexual health competency d. Sex-positive framework defined e. Comfort increased f. Sexual health conversations
4. What experiences have counseling psychologists had with sexual health training within their graduate programs and outside of their programs?	g. Absence of training and supervision h. Absence of continuing education i. Educational suggestions
5. What role does the counseling psychologists' personal values play in assisting clients with their sexual health?	j. Relevance of personal identities and values

Guiding Question #1: How do counseling psychologists feel about their competency in sexual health to assist clients?

The theme developed from this guiding question revealed how counseling psychologists feel about their competency in addressing the sexual health needs of their clients. The primary theme developed from the question was *ability increased*. This theme provides an in-depth analysis of the participants' specific experiences and examples of how they feel about their ability to assist clients with their sexual health needs. A discussion of the various influences that effected the participants' ability is also reviewed.

Ability Increased

All of the counseling psychologists interviewed identified an awareness of increased ability to assist clients with their sexual health needs. Most of the participants reported feeling "okay" or "fine" with their ability but identified that these feelings developed over time. They expressed an increased ability to assist clients with their sexual health needs over the duration of their career and identified specific elements that aided with this process.

Michelle discussed how her ability to inquire about sexual health topics with clients has increased over time as a result of her own professional development and interests in sexual health. Specifically, she identified that sex and sexuality have long since been personal interests of hers in which she has personally sought educational opportunities to gain additional knowledge and skills. Further, she was especially forthcoming about how feels her ability has been directly affected by the absence of graduate training and competent supervision in sexual health. Below she reported experiencing feelings of incompetency at times due to her level of ability to explore sexual health with clients:

“...I think it's just again like not having a good foundation, not having a lot of training or supervision around this. You know I'm. I don't always feel like I know what I'm doing...”

Donna discussed how she feels “pretty comfortable” with her ability to assist clients with their sexual health needs. She expressed how this feeling developed over time and was the result of various forces that were present during the onset of her professional career. Specifically, she reflected on her involvement in the AIDS crisis and professional conversations that occurred as a result of social awareness to this topic. She reflected on how her involvement in a sexually relevant social movement encouraged active dialogue with colleagues in-person and through the use of active list-servs. Donna also discussed how this social lens encouraged her to engage in more self-study on issues related to the AIDS crisis and its potential effect on her clients. Below is an example of how she felt that the social lens at the onset of her professional career shaped her ability to assist clients with their sexual health needs:

“Probably, because everything comes over time. But being, I guess the AIDS era really wasn't when I was in graduate school, but I was a very early professional when the AIDS crisis hit. And we had an AIDS education committee at Ithaca college, like loads of colleges did at that time, and made flyers, and you know, trained RA's and did all that sort of stuff in terms of encouraging people to practice safe sex practices. So, I was kind of fortunate to have sort of come into the field in that era.”

Lastly, Donna identified how her personal experiences interacting with individuals of varying sexual orientations on a personal level influenced her ability to better assist clients with their sexual health. She also reflected on how her experience working with the LGBTQ population at the onset of her career during an era that initiated a conversation about sexual orientation further assisted with her ability to navigate sexual health conversations:

“I think very early on I wasn't as comfortable with gay sexuality. Then my brother came out and that solved that problem. I found that I became an advocate for them. I was, there's a term for it. What is a gay ally, I guess? Yeah. So that's the only thing that I could think of that I grew into...So, you know so and so having worked with the gay and

lesbian population, now LGBTQ, working with that population during that era, also I think gave me some of the knowledge and skills and comfort level.”

Rachel discussed how she feels “okay” about her ability to assist clients with their sexual health. She reflected on how this feeling was influenced by her lack of training on the topic in graduate school. Since she has begun her professional career, her ability has increased over time due to her own self-study, influence of professional relationships and educational opportunities, and relocation to a California, a geographical area that she feels is more focused on highlighting the relativity of sexual health in their clients’ lives. Rachel also highlights the inconsistency of training that is present in different geographical locations and in the curriculums of sexual health courses that currently exist. Below she described her experience with the shift in her ability to assist clients of various relationship configurations was influenced by her increased exposure to these populations upon her relocation from the east coast to the west coast:

“So, I mean I feel ok about my skills at this point, but I definitely feel like I didn't get enough training in it like in, in grad school it was not a clear focus. I think I've had to do a lot of training since then. Like there was one human sexuality class you could take as an elective during my grad program but in the five years I was there it was offered only one time and it conflicted with internships so I couldn't take it...In California there's a requirement for your license you have to have training in human sexuality which is cool. And so I did have to take it like I took that required class when I got here before but that required class was horrible like there was this one online version that I had like I didn't quite say this because basic like the uterus is a baby cave, you know, it was like all about sexual, like that women sexuality exists just for procreation...coming to the Bay Area, there is, they're like so my training was in the East Coast, and then I came out to the Bay Area where I still am for school, and a big part of kind of sexual health had to do with like learning more about and understanding like poly communities and kink communities out here. And so that was a big shift for me, I feel like that was never even talked about in any of my training in the East Coast and coming out here is like oh yeah I need to know, like I need to really understand what I like, why I just thought monogamy was what everyone did because that was all anyone ever talked about and like really examining that.”

Rachel also reflected on how she has sought educational material and support from colleagues to increase her ability to assist clients with their sexual health needs. Below is her

reflection of obtaining professional connections and resources from others interested in sexual health within the Bay Area:

“One of my colleagues she was doing her predoc while I was doing my postdoc. She's amazing and was like a sexual health educator. And so, she did presentations for us on sex therapy and so like they brought in folks who did seminars on sex therapy and I'm looking at these things. We had good folks we could refer to and consult with. And so, then like of course she's always my go to with like okay what's the book that I can read. What's the bibliotherapy that we can use here what are the things that we can bring in to have this happen. But I definitely had to do a lot of my own stuff for that.”

Rebecca discussed how she feels “average” about her ability to assist clients with their sexual health and proposed that this was related to her lack of training in sexual health throughout her professional development. She reflected on how her ability is dependent upon the specific sexual health topic and the population she is assisting. She discussed how she primarily works as a military psychologist and feels most confident about her ability to assist veterans with issues related to pornography or sexual abuse. Below she reflected on her ability to inquire about certain sexual health topics is related to the specific job duty she is completing:

“We are pretty good so our assessments of for certain jobs like if you want to be white house security or you want to be an embassy security guard secure our embassies overseas there are certain jobs that we do ask very specifically about pornography use and visiting prostitutes because those are two things that can lead to. It can indicate poor judgment, first of all, and secondly it can contribute to your ability to be coerced or bribed so they won't let anyone do that job if they have significant financial debt because they're vulnerable to bribery or coercion so that there we ask about it. So, like how often are you masturbating? How, do you use pornography every time you masturbate? Is the pornography anything, you know, what is the topic or style of the pornography? And then sex for money, sex with multiple partners, stranger sex, that gets asked. In my intakes, I honestly don't. We do, I do when it's for substance abuse, I do ask any other compulsive behaviors we should know about common ones are video games, sex, pornography, gambling. So, I ask, I ask that, but they typically brush through it and go no, no, no.”

Sonia reflected on how her ability to assist clients with their sexual health needs has increased over time as a result of her professional development in a primary care setting. She discussed how the primary care setting has provided a standardized framework of how to discuss

sexual health with clients. The primary care setting normalized the topic of sexual health and provided a framework that was modeled for her by other clinicians and medical doctors. Given that the model for addressing sexual health has been somewhat standardized in this setting, particularly in the intake process, she discussed how her ability to address their general sexual wellbeing is not as strong or likely to be addressed.

“Every patient who completes an initial evaluation over the age of 11 we inquire about their sexual history and drug and alcohol for every patient. It's just standard care within the Geisinger health system. And so, I think asking questions about you know have you ever had sexual intercourse? Have you ever had any sexual acts, have you engaged in any sexual acts? I think it opens up the conversation, we say this is just our standard procedure and then I think as a result of that if someone says, Yes, right we might say, OK are you using safer sex practices? And then we talk about that which that opens up conversations about how many partners do you have? And I think that it opens up a conversation about what, what do you have female partners? Do you have male partners? How many? How often are you doing this? Are your parents aware, aware? So, and also just discussing kind of possible long, short- and long-term consequences of having unsafe sexual you know sexually engaging in unsafe sexual acts. So, I think it just allows for us to have this conversation and in a way that I think wouldn't naturally just happen.”

Prior to her entrance into primary care, she reported that she did not feel confident in her ability to assist clients with their sexual health and as a result often did not initiate the topic with clients. Below she reflected on her reluctance to initiate sexual health conversations with clients and how her increased ability in addressing sexual health with clients was setting dependent:

“I would probably say I did not talk about it. And some of it was just me. Yeah, I think some of it was because it wasn't a role modeled for me. I think it wasn't integrated as the standard procedure in our service delivery and our information that we gathered from families...”

Guiding Question #2: What role do counseling psychology values play in the experiences of counseling psychologists in assisting their clients with sexual health?

The theme developed from this guiding question reflects specific values that participants assigned to counseling psychology and how they influenced how these values guide their treatment in assisting clients with their sexual health. The primary theme developed from this

question was *connection of counseling psychology values to sexual health*. All of the participants identified specific counseling psychology values that led them to this specific branch of psychology. They discussed how those specific values have been influential in their conceptualization and conversations about sexual health. A discussion of how their counseling psychology values affect their experience in addressing sexual health with their clients is reviewed.

Connection of counseling psychology values to sexual health

All of the participants interviewed identified specific values of counseling psychology that drew them to the field and influenced their conceptualizations of clients. The participants identified similar values such as the focus on context, social advocacy, multiculturalism, systems, and holism. Further, all of the participants discussed how these values influence their sexual health conversations with clients.

Michelle discussed how she previously worked in public health and sought a career change that aligned with her values. She reflected on how counseling psychology values primarily influenced her interest in the field. Specifically, she reflected on how the values of context, person-environment interaction, role of systemic structures, multiculturalism, and social justice are integral to her understanding humans and human functioning. She discussed how she has used these values in various settings such as university counseling centers, VA hospitals, community mental health centers, and private practice. Similarly, these values have been relevant to how she has addressed sexual health issues with clients in the various settings. Below she discussed how “in theory” she aligns her counseling psychology values to her conceptualization of clients’ sexual health needs. Specifically, she reflected on how awareness

to cultural perceptions of sexual health for marginalized populations is important to reflect on when considering the value of social advocacy in counseling psychology:

“If we're talking about social justice and advocacy for example. Like sex and sexual health and wellbeing, to me are like particularly salient for people marginalized groups of people who've been sort of told that their bodies are wrong or that sex is dirty that. That they're their sexual behaviors and attractions are like illegal and indicative of like you know like all kinds of problems from a moral, judicial and sort of pathological standpoint then it seems even more important. I think everyone is entitled to like accurate information about their bodies and sex and sexual health and also good sex and pleasure. But it's like. It's particularly salient for groups of people who've been historically pathologized or criminalized that they have access to all of those things. And I think. Like. Counseling psychology could play an important role in that. From like from a variety of values that are connected to counseling psychology but in particular the social justice piece.”

Donna reported being strongly aligned with counseling psychology within her training and practice. She identified that she was previously affiliated on an administrative level to the American Board of Counseling Psychology and an active participant of APA's Division 17, Division of Counseling Psychology. She discussed how she “views people within the context of their environment; “look at their strengths, their culture, and their background”; and uses a “phenomenological” lens to conceptualize clients. These values have been present in her professional practice in university counseling centers, private practice, as a consultant for adoption agencies, and research focused on diverse populations. Below she reflected on an experience with a colleague in which she realized how her conceptualization is unique to the counseling psychologist experience:

“...a colleague of mine when I first moved to Pennsylvania, she, she looked at me and she said you're different than any psychologist I've ever known. She was a social worker at a hospital, and I said, really? And, I said How? She said that I already figured it out. I said, what? She said, you're a counselling psychologist not a clinical psychologist. And she said the people I've known have been clinical psychologists and they were all into tight diagnostic categories and testing and all they could talk about was testing and symptoms. And you view people more like I do as a social worker although you have the knowledge of a psychologist, but you view people within the context of their

environment. You look at their strengths and their culture and their background and more phenomenological. So, I guess you know the hallmarks would be.”

Further, Donna also continues to use these values to shape the context of sexual health discussion discussions with clients. Donna reflected on how she feels counseling psychology is congruent with sexual health competency as they both unite and together can shape the direction of treatment:

“...I would never you know if I both with disassociation and of course the abuse survivor thing if I was looking at any of these people, you know the guy who is very interested in violent porn films, but, but doesn't know how to talk to people that he's interested in like I view that from a strength, from a skill development perspective, and an insight oriented perspective rather than a boy are you screwed up kind of perspective. There are elements of that but that's not therapeutically valuable.”

Below is a reflection of how Donna views the topic of sexual health as an individual and systemic issue that is directly related to her values as a counseling psychologist. She highlighted how her interactions with clients can be used to systemically identify global issues, of particular relevance to sexual health, that are impacting individuals of different cultures. Additionally, she also focused on the value of being a social advocate and raising awareness for sexual health issues that are contextually effecting clients:

“...so, I've kind of view it more from a systems level as well as the clinical level, and I think that keeps me inspired and committed. And I also think, I mean it's a little bit of a counselling psychology thing. Well actually it's probably a big counselling psychology thing not only viewing it from the point of view of the damage it's done from my patient, to my patient, but also how can we use this knowledge to rise it up a level, and how do we view it from a broader cultural lens, and get involved in things like the allegations committee for this dioceses and professional organizations to raise awareness that these sorts of things...”

Rachel reflected on how mentorship from undergraduate professors influenced her interest and passion for the field of counseling psychology. Prior to interactions with these professors, she reflected on ambivalence about pursuing careers in the field of clinical psychology or social work. She felt that both professional areas focused on important values but

felt that something was missing that fully resonated with her personal values as a feminist. Her overall goal was to unite the values of her psychology concentration with “the other part” of herself as a social advocate:

“So, yeah, I picked counseling psychology, I was really fortunate when I was in grad school to have a few professors who were trained as counseling psychologists teaching like my counselling skills courses and things when I was an undergrad. And I think for me it helped me to clarify like I felt like clinical was really more focused on like everything I learned from them was like it's behavioral it's focused on internal sort of thing that's very individual focused and then I was interested in social work but that felt a little more just like systemic only. And I really liked how counseling psych kind of seemed to bridge the two had both like an understanding of social context and, and everything that's going on and an ability to work at a systemic level but also bringing in the biological the individual kind of bringing all of that together. And then I also, like I was really active I was feminist activist in college, and so for me the idea of like how to bring everything I was learning in my psych major together with this other part of myself which is more of a social advocate. And, I, it was only seeing that happening in counseling psych programs...”

Rachel also felt that counseling psychology most specifically aligned with her values of wellness, systems, social advocacy, holism, and multiculturalism. These values also help navigate sexual; health conversations with clients. The quote below reflects how Rachel uses her values as a counseling psychologist to conceptualize and support clients in their sexual health journeys, as well as explore her own presumptions of sexual health. Additionally, she reflected on the importance of approaching the client from a wellness and holistic perspective that is interested in identifying areas of their self that could be supported to aid in their sexual wellbeing and flourishing:

“And so, for me a lot of the sexual health stuff has to do with, like, what does it mean to have optimal performance or what does it mean to have like sexual flourishing. So, I think that's, that's a big part of what I'm looking at like looking at with all of my clients. What is, what is a healthy expression of sexuality for them?...like I need to really understand what I like, why I just thought monogamy was what everyone did because that was all anyone ever talked about and like really examining that. And so, for me like that was it that's a big piece of it to really understanding what are the relationship configurations that works for people or not relationship. How is kind of asexuality to kind of you know hyper sexuality. There's also a lot around yeah, like is sex addiction a thing,

is it not? So, there's like lots of those sorts of things that kind of come up out here. But yeah for me it's just really understanding like what, what is it, that, that a person would like for there or are there are there pieces that feel like they're not being their best selves in terms of their sexual well-being. And then how do we how do we work with that?

Rebecca practices primarily as a military psychologist and uses her counseling psychology values to navigate her client interactions. For her, the values of a strengths-based perspective, multiculturalism, supportiveness, and holism primarily drive the foundation of her professional work. She utilizes these values to initiate sexual health conversations during assessments for various government jobs and with veterans in individual therapy. Below she describes how her counseling psychology value of wellness is used to guide the framework of her sexual health conversations with clients. She believes sexual health is also only one part of an individual's identity that deserves to flourish and perform at optimal performance:

“To me it means basically taking a strengths perspective versus an illness perspective and then focusing on prevention and some more like working with healthy populations maybe a little bit more than clinical would...So instead of maybe clinical would care more about symptoms and sexual health and maybe we'd be more about like it's, it's one element of your identity is your sexual identity or your practices or whatever...a health perspective so we probably would consider that even normal functioning to be something that you could improve upon through counseling or through therapy. And I guess we would think of it in the strengths model so it's one of many parts of a human being.”

The focus of viewing client issues from a systemic approach is a hallmark value of a counseling psychology. Sonia identified a systemic approach as the primary motivator for her to pursue a career within the field of counseling psychology. This value has been especially relevant to her work in integrated primary care by motivating her to provide accessible care to all patients regardless of systemic issues that often hinder their access. She reflected on she feels most suited as a counseling psychologist to engage in sexual health conversations with clients due to its relevancy to a client's general wellbeing:

“Well I think that you know I think it's not only counseling psychology, but I think it's our role. I think sometimes we, we as psychologists establish very strong relationships

with patients and families and often teenagers are more likely to open up and share with us about their sexual behaviors. The question, they might be more likely to discuss sexual questions related to sexual health with us before a pediatrician because the pediatricians only seeing them for well child visits or if they're sick. And so, we have more frequent contact with patients who've established a service with us. So, I do think working in primary care. Not, not talking about it would be an injustice to a family and to a teenager and to children. And so, I think we're well suited in this context thinking about just the setting to really be to evaluate our level of comfort with doing that.”

Additionally, Sonia remains motivated to consider the cultural identities and contextual factors that interact to define a holistic conceptualization of her clients’ needs. Her quote below describes how she integrates the cultural family patterns and potential social influences to conceptualize how sexual health conversations can systematically be formed for her clients, especially children. By considering all of these potentials overplays, she can hypothesize how the contextual and cultural dynamics can shape the overall system of the child’s understanding of sexual health:

“So, I think you know I think in general if I open up a conversation very openly, so I'd like, just to talk about an example of a referral I just got. This is not the same person I talked about, but they're coming in because the patient is like a 10-year-old kid and he is having intrusive images and thoughts about sexual things. And so, you know it's complicated because he's 10 and so one thing that I really made sure to do is really understand the family culture around these conversations. So, what conversations do families have around this? Where are kids getting it? Where are the kids that I'm working with getting knowledge about, you know, anything related to sexual health? Are they getting it from school or are they getting it from friends or are they getting from online, parents, extended family members? But also, really understanding the kind of family's perspective and view of sexual health and discussions of sexual health.”

Guiding Question #3: What meaning do counseling psychologists apply to a sex-positive framework?

The themes developed from this guiding question revealed various factors about how counseling psychologists define sexual health competency and its influence on how they address the topic with clients. Additionally, the themes also identified how counseling psychologists define a sex-positive framework as related to their work with clients. The themes developed from

the question were *sexual health competency, sex-positive framework defined, comfort increased, and sexual health conversations*. All of the participants initially struggled to identify a clear picture of sexual health competency, but eventually stumbled on the general competency components of knowledge, awareness, and skills to be relevant in defining sexual health competency. They felt sexual health competency should be ongoing within those areas and defined similarly to competency standards for other areas of psychology such as multiculturalism. All of the participants provided similar definitions for a sex-positive framework and identified values that are of relevance to the field of counseling psychology.

The participants all discussed how their comfort has increased over time and identified other dependent variables that influenced this internal process. Additionally, they acknowledged specific instances in which they continue to experience discomfort with the topic of sexual health. A discussion of how their level of comfort impacts their experience in addressing sexual health with their clients will be reviewed. Lastly, all of the participants reflected on various conversations they have engaged in with clients about sexual health and the topics that were most frequently explored. This section will highlight the relevance of sexual health in the lives of clients and the experiences of counseling psychologists exploring its various avenues.

Sexual health competency

All of the participants defined sexual health competency as having adequate knowledge, awareness and skills in sexual health. They also identified additional values they felt were important to recognize specifically in regard to the topic of sexual health such as openness, cultural relevancy, and understanding of social contextual factors. A reflection from each participants' experiences of sexual health competency will be reviewed.

Michelle identified sexual health competency as being similar to that of multicultural competency. She viewed these competencies as being an “orientation” to competency in which the process is ongoing and has no beginning or end to the process. More specifically, she felt this ongoing process would occur with the psychologists’ knowledge, awareness, and skills of sexual health. Michelle felt the three components of competency could be extended to reflect the psychologist obtaining accurate knowledge about various sexual health topics; foundation of self-exploratory processes of one’s values as they relate to sexual health; and skills that would aid a psychologist in broaching or navigating sexual health conversations. Michelle also felt that being able to approach sexual health with clients with an open, non-judgmental attitude is conducive to sexual health competency. She experiences the ability to have more direct and meaningful conversations with clients about their sexual health when she conceptualizes competency through this model. Below she reflected on how her orientation towards sexual health competency allows for more open sexual health dialogue with clients:

“Well I don't know. I like I like the recent work coming out about like multicultural competency. Like is being sort of reconceptualized as a multi as an orientation to multicultural work and diversity because there is really there is there can't be like a beginning or an end. Just given the vastness of human diversity and so this idea of having like an orientation toward sexual health competency would be like you are open and non-judgmental and have accurate information about different kinds of bodies and different kinds of sex and different kinds of sexual relationships. So, I think there's like a there's I don't know that there's a beginning and an end in terms of like knowledge but it's more of an orientation towards. An orientation towards knowledge, awareness, and then like having skills to be able to actually have like frank conversations with clients about sex and sexual health.”

Similarly, Donna felt that sexual health competency is also defined by possessing adequate knowledge, awareness, and skills in sexual health. She felt that psychologists should be aware and knowledgeable about socially relevant sexual health topics; power differentials within the therapeutic relationship; and the importance of cultural relevancy. Donna reflected on

the development of her sexual health competencies of skills and awareness, specifically with the LGBTQ population, through professional experiences during an era when awareness was beginning to be raised for this population. This highlights how her competencies were developed over time and through professional experiences:

“So, while we talk about knowledge, attitudes, and skills right, in terms of competencies, so certainly knowledge is needed about the issues of the day, really. You know if those issues include child trafficking patterns in your community or knowledge about how AIDS is transmitted or knowledge about, knowledge about positive sexual interactions and the ability to say no and what does full consent mean...Being an older female too I have to be careful to kind of keep boundaries too so I, I may be a little bit less explicit than I was when I was younger because it's kind of like talking to your mom. Some people are like I don't know if I want to do that. So anyways bunches of knowledge whether that's any kind of knowledge...I was the like mom of small children who kind of went behind him with a little broom and, and, got the Gay and Lesbian Alliance through the Board of Trustees. So, I was less threatening than Jim to them. So, you know so and so having worked with the gay and lesbian population, now LGBTQ, working with that population during that era, also I think gave me some of the knowledge and skills and comfort level.”

Further, she discussed how communication skills have been necessary in order to initiate dialogue about sexual health without provoking shame. Importantly, she also advised professionals to remain open to the “phenomenological experiences” of the client “within the context of their community”. This is reiterated below, as she reflected on the importance of being aware and knowledgeable about how culture can shape a clients’ sexual health experiences:

“...I had a client, this was in Maryland, who was Iranian and she was extremely critically suicidal and we talked about it she also happened to be infertile and the case manager told me do you know that in the Iranian culture women who are not able to produce children are expected to at least to offer to kill themselves. This was in probably nineteen 86, 87. No, no, no, no what am I saying, we didn't move back there until 88. So probably 89 or 90 and so, kind of recognizing that cultural values in sex, in marriage, and in giving birth. All those sorts of things so not that you can know everything but at least being open to learning everything and what you need to know changes over time so of course you can't know everything, you can't know everything about anything. So that's knowledge skill added, I think, I think honestly attitude is probably more important than knowledge or skills.”

Rachel also felt that sexual health competency is defined by having adequate knowledge, awareness, and skills. In reflecting on these components, she shared her experience of developing her sexual health knowledge and awareness easier than her skills. She attributed this difference to lack of competent supervision during the onset of her professional development to guide her in developing skills to address sexual health topics. Instead, she reported that she gained her skills primarily from consulting with competent colleagues over the course of her professional career:

“...I mean so being aware of like a sex guidelines and stuff like I definitely think about that in terms of like I would never advertise my health as a sex therapist, or you know like those or so I think there are some really clear ways. But I think that's hard too because like I have a couple of students right now that want to become certified but there's no supervisor the closes supervisor is 8 hours away. And so, I think for me like competency it's like the general like do you have knowledge awareness and skills. And I think knowledge and awareness are easier to gain and do the skills part is hard, like I often like the way that I handle like I don't really have a supervisor that I can go to and say like you know what about this. But I do have some colleagues that I consult with. So, I have some consultation that I do like the one who is my friend who is an expert who I have two of them that identify a sex therapist. I can talk with them de-identified info and be like OK here's what I'm doing that that makes sense. Yes OK. And they'll give me new resources and we'll do this...I don't I guess I don't have a very clear definition of competency. I do know there's ways that I wish that I had access to more supervision around these things in practice, but a lot of my supervisors weren't necessarily, didn't necessarily know more about it than I did, and so it's hard to, yeah, balance that.”

Below Rachel reflected on two different components of sexual health competency; the process of self-exploration of one's values of sexual health and their implications for creating a safe space to avoid provoking shame in clients about their shared experiences; comfort with general knowledge to help guide their practices; and exploration of their personal values to avoid projection of them onto clients. She reflected on resources that have helped her gain these competencies and the goals she attempts to achieve by practicing through them:

“...I think there was that great TCP special issue on like sexual...And I loved that one. And I think they laid out some really good kind of basic skills that folks should have.

But I think a big thing like it's similar to cultural competency right it's like I struggle with this. That's a class I teach in and how, like, is there a whole list of knowledge that you should memorize or is there like a way of being that you should have that helps you do this? And it's like both but I do think like the comfort and the ability to like, like, for me my biggest thing is to be able to hear anything and not be like not have a reaction...And so that's the part that I am always looking at is like how do I like how does not trigger shame? It's like a big skill and to recognize that and that requires your own self exploration. And so, you know doing that, and like being like, yeah, being comfortable with the vocabulary and the anatomy and just all of that stuff and really figuring out like where, what are your own values and really realizing that those are just personal or values and, and making sure you're not kind of projecting that out on to others.”

Rachel also discussed how she felt her competencies in sexual health should have been gained in her graduate training within courses or clinical placement opportunities. She remained sensitive to the constraints of current curriculums and identified an alternative solution to how these competencies might be incorporated for future trainees:

“I mean there's so much that we need to learn right. I, I definitely, I think like at internship sites it's, I think it's important for that to like, like the supervisor level for that to be there but right we can't have those supervisors unless there's something probably happening in schools. And so maybe as part of like internship or practicum courses having that be an intentional model. It's hard to like you could add on another class but there's already so many classes that a psychologist has to take. And then you know I do like that California has the required that you have...Like I so I train MFT's right now and they do have a full class that's, that they take on human sexual, that's like sex therapy learning about all these different things and so I do see that as super useful. I just don't know what you take out to put that in within a training program. So I do think maybe it's like changing the way that we teach though like couples and family class or changing the way even that you can find it to couples and family it kind of says like this should be a thing that happens in couples and families it's not necessarily this broader so yeah it's not a good answer but I'm all over the place with it.”

Rebecca reflected on her feelings about sexual health being a foundational competency, but her preference for those interested in the topic to address certain areas of sexual health with clients. As discussed with other participants, she also reflected on how knowledge, awareness, and skills are important components that define sexual health competency. She felt that knowledge about certain sexual health topics, such as sexual dysfunctions, and the skills to address them is especially necessary to being competent in sexual health. Rebecca also felt that

gaining knowledge about the general consensus of sexual health topics might help her better understand topics that are more prevalent will encourage her to initiate the conversations:

“...I think I'd be fine and I think it's more to know how, which topics on when are recommended you know and then like if somebody gave me a presentation on you know 50% of your patients or 50% of males and 20% of females have this problem and aren't telling you about it things to remind me like where I could walk out and be like yeah I really zero of my patients talk to me about that and odds are half of them experience it I should keep that in mind.”

Rebecca also reflected on how these competencies can be further shaped by her practice as a military psychologist. For example, she reflected on how specific knowledge and skills related to sexual health of veterans would be especially helpful for her professional development. Similar to other participants, she also reflected on the relevance of maintaining an awareness of the social context and how this has implications for addressing sexual health with clients. Below Rebecca discussed how her role as a military treatment provider is to competently engage in explorative sexual health dialogues with clients to help them understand their experiences with sexual health and its potential connection to their distress:

“Yeah, they're very open in talking about masturbation and pornography. Like I said they'll there's like this phenomenon of a combat jerk which is masturbating after like a really intense firefight. You know you've got all this pent up like just aggression anxiety whatever. So, it's kind of a coping skill for a deployed service member. They, they joke about it as far as there's like a certain stall of porta potties on deployment where that's what it's for you know it's for masturbation or they...I don't know that it's the most respectful of other people like I said it could easily offend people the way it's talked about because there's lots of religious people in the military there's lots of people with sexual abuse histories and people who don't want to hear about it. But yeah, they're just super open, but it's not the most respectful of women either if they're talking about having sex. It's not the most respectful so...one of our LCSW's received a consult that was for premature ejaculation or some sexual thing and he declined to take it. He sent it to one of us because he said his state does not allow him to do sex therapy. But to me that's not sex therapy anyway that was it's a different thing...I think we should be able to talk about stuff like performance anxiety or what. You know what. What are you attaching to sex that's making it so difficult?”

Similar to all of the other participants, Sonia acknowledged that sexual health competency is defined by one's knowledge, awareness, and skills. She reflected on how these components are also recognized in counseling psychology as a framework to describe general competencies across various topics in the field. Through development of these competencies, the psychologist increases their professional development, and with an awareness to cultural contexts, they can better assist clients with through delivery of competencies:

“I think you know in most in most areas when you're thinking about competency you're thinking about knowledge and understanding. But I think there's a second layer of it is like the actual I think there are a couple of layers to it, I think there's another layer of like a personal level of comfort and really exploring kind of your level of comfort with it. And then the next piece is like how do you effectively deliver this, while considering all factors right like all the moving parts that come up with providing best care and best practice or service delivery to families and patients, you have to really think about like how do you apply this and how do you do it well? So, I think it's got to be knowledge and willingness and level of readiness to do it. But also recognizing that we all come with our own biases and kind of culture, cultural frameworks to sexual health and what that means it and what it looks like. And so, what we bring to it I think is important but also what our history and our own experiences of sexual health and conversations about it also are important to understand and recognize.”

Sonia also discussed how the integrated primary care environment has been the most supportive in helping her develop these competencies by providing opportunities to consult with and observe colleagues engage in sexual health conversations with clients. She felt the supportive environment has resulted in an increase in engagement of sexual health conversations, which has naturally assisted in strengthening her sexual health competencies. The quote below highlights her belief that trainees might benefit from integrating these competencies into their training while also obtaining them through practical experience in clinical opportunities:

“Yeah, I think in some ways you know some of these skills kind of you can learn them in class you can learn about it. I really think where it can be it is hard because unless you are actually practicing it it's hard to translate what you learn in books and what you learn in class to really translate to the actual treatment that you're doing in the room. And so, I think some exposure to it and having conversations about it during you know internship probably will be better when they're really focusing on or even just some of the basic, I

guess clinical skills training that we get during grad school they might talk about how you might also introduce or discuss sexual health. Right. So maybe that needs to be introduced in grad school. But then when you're on internship you're talking about intakes and appropriate questions that we're really incorporating that in there. And I think some of it is it just is not as weird to talk about sexual health in a primary care setting. I mean I think the reality of it is it is also setting dependent...And so, in primary care this is just what you do right. We have it all. So, people where you know we're seeing teenagers that are pregnant so duh you have to talk about it, right? You're as they ask at every, at every well child check you know they talk about actual sexual health and they're talking about engaging in safer sex practices. So, I think these are just natural things that happen in primary care. And so, I think it's setting dependent.”

Sonia also acknowledged that pediatric primary care might require some unique competencies for psychologists due to the added dynamics that are often involved. Further, she discussed the difficulties that might arise in translating the skills learned in class to clinical practice with this specific population. Below she reflected on how the interplay of the family adds dynamic to the competencies, as relevant to any issue explored in the session:

I think that I think there are some unique competencies and skill set when you're when you are interviewing and interacting with younger you know pediatric patients versus adult patients. I do think some of that is like on the job on the job learning. You know it's like you can you can talk about how do you do this with a kid? But then you get in a room and you're like wow you did not with that are all the other 14 factors that are going on in this room. And so, I know I know with people that I supervise and train, some people said that you know I never actually worked with the kid. That kid was never in the room. I worked I was trained to work with parents to teach them strategies. And I just I'm like Oh well that's not what we do here. Like you know you intervene with the kid if the kid is running down the hallway. I was like, nope, no thank you we walk in the hallway we're going to start all the way at the beginning and I physically guide the kid back to the beginning and make them redo it. And so, you know I think part of what was unique about working with pediatric patients is I really incorporate this idea of how do I role model all the skills that I would I'm encouraging the parents to implement? Right? Like if I can't role model for the parent and I can't show them that this works how likely that they're going to go and go and go and implement these skills in the home without me present.”

Sex-positive framework defined

All of the participants identified values that represent their understanding of a sex-positive framework. Although some of the participants reported unfamiliarity with the term,

they identified their understanding of the concept and developed insight into its connection to their current practices. Most of the values identified by the participants were reflective of the values that are present in counseling psychology. Sex-positive values that were frequently discussed by the participants were non-judgmental, openness, culturally sensitive, and holistically focused. A discussion of the participants' individual understanding of a sex-positive framework will be reviewed.

Michelle connected her understanding of a sex-positive framework to her feminist roots. She reflected on how her conceptualization of sex-positive developed as her understanding of the feminist movement progressed toward the contemporary third wave of feminism. To her, this is a paradigm shift in thinking of sex as a human right that can be experienced and expressed freely. She actively uses this framework to value the diversity of worldviews around sexual health and to ground her perspective of the client's behaviors in health and safety:

“...So, I was a sort of a feminist and social justice-oriented person long before I found psychology and, and so my earliest. It's like it's the thing that I think of when I think of sex positive I think of like before I before I was sex positive like I remember being an undergraduate and like to in the late 90s and writing a paper about like I was really into Andrea Dworkin and Catherine McKinnon and is really into this idea that pornography was always bad and always hurt women. And that until sort of pornography was banned or outlawed then you know women would never really be free or equal in society. And then my opinions about that kind of evolved over time to where to like to me sex positive means really a paradigm shift in how we think about sex and women's bodies in particular in a sexist society. That the answer can't just be that I mean Andrew Dawkins said that like all heterosexual sex is rape like that can't be the answer. That's not a workable paradigm for me. So. So yes, sex positive means a paradigm shift in thinking about sex as a human right.”

Below Michelle provided an example of how she used a sex-positive framework to navigate sexual health with a client that is an exotic dancer. She discussed how she approached the client from a non-judgmental stance and assisted the client in exploring her experiences of

being an exotic dancer. The psychologist avoided pathologizing the behavior and engaged in a self-reflective process of her reaction to society's label of the client's behavior:

“...working with someone who was who danced who was like an exotic dancer...I was a sex positive feminist and that I wasn't going to judge or shame her or try to locate the problem within the fact that she was in fact doing this kind of sex work. And that was that was meaningful to me...It's sort of the, the it's the it's not only that the absence of judgment and shaming and like locating the problem within a behavior that you know society has labeled as bad or wrong or problematic. It's also like the presence of some sort of respect for autonomy and respect for her like her, her choice to do that as like a legitimate career choice in addition to like helping her explore and ask questions about you know, what if that was getting her what she wanted or what she needed at this moment in time in her life...not pathologizing the behavior and like respecting the person in addition to exploring helping her explore and leaving room for the possibility that the dancing wasn't the problem.”

Further, Michelle expands on the idea that sex-positive clinicians do not close off the possibility that a client's sexual health might be problematic, but instead join the client in exploring the client's experiences with their sexual health. A sex-positive framework supports the health and safety of a client's sexual health choices:

“And I think that if I can say like one more thing about that but what it also doesn't mean to me is that you. That as a clinician that you because you have sort of the sex positive framework that you close off the possibility that it might be problematic for this person or like you close off really like you're joining the client in exploring like, like it and asking questions and help and exploring like whether or not this is in fact connected to a larger set of issues of the client is bringing with them. So, it's like it's, it's like. I heard somebody say once and it was so smart that like being multicultural response responsive doesn't mean that we, we say as mental health professionals that all behaviors are OK because of culture like that. That that doesn't make any sense. That's cultural relativism and that. That. That framework I think is, is, is inconsistent with what we try to do as mental health folks. And so, she said like you we've got to ground it in something. And she was like in my practice I choose to ground my perspective on evaluating like a client's behaviors or experiences that's grounded in health and safety.”

Donna approached her understanding of a sex-positive framework with some uncertainty that she attributed to her age. She reported that her training occurred during an era when sexual health was focused through a “sex negative” lens. She defined a sex negative lens as one that focuses on ways that sex can be used to harm people:

“Well I don't think I was ever taught anything. I was never taught that sex, sex was negative. I never was taught anything about sex being shameful nor did I feel it. I mean we came straight out of the 70s liberation generation. But, I'm more aware of the negative things that can happen.”

Donna reflected on how her early professional experiences with sexual health was shaped by a culture that narrowly focused on rape education and identifying ways that sex could be harmful. Although she supported some values of a sex-positive framework, her uncertainty about individual sexual freedom remained connected to her personal values. Below she reflected on how her generational values of sexual health has shaped her understanding that a sex-positive framework can be harmful at times:

“...So, as an official old, old person this is a little out of my cultural terrain. But, but sometimes, so my image, and this may be correct, and you can tell me if it is incorrect because I would like to know this actually. That some, some parts of the sex the so, so, my knowledge of it is very limited and is kind of like all sex is positive that, that women should be, well everybody, should be free to but sometimes that message can be dangerous. Danny said, I remember the day when you'd look out there and there'd be a thousand men screwing each other all at the same time. And I'm thinking, ew. Not because of the gay thing but that kind of you know my age group is more about privacy, and chill on the exhibition a little and anonymity. I'm not sure that's healthy. Just based on what I've seen, but I'm from a different generation. So, some of those things I think, the outer edges of sex positivity could be used in ways that could be harmful.”

Rachel reflected on how the absence of graduate training in sexual health led her to explore a sex-positive framework due to its connectivity to her feminist roots. She sought out literature on sex-positive and engaged in self-education to better support her clients in the exploration of their sexual health. Through a sex-positive lens, she understands sex as a right that is fundamental to wellness. Sex-positivity is being “affirming about sex” and requires self-exploration of one’s own values of sex and how to avoid projecting those onto others:

“...I mean I guess it's like being affirming about sex, that sex, that there isn't. Sex is a biological thing that we do that can be a source of joy and wonderment but can also be a source of people's deepest pain and shame and other things and so for me it's this idea that I think all of us are entitled to like a beautiful safe and comfortable relationship with our body and our sexuality whatever it is that we want or don't want, and to be able, like

for me being sex positive is to accept like folks wherever they are and to help them figure out like why are there yeses and why are their no's, no's, and is that what they want it to be, and if it is how do they communicate that and get what they need in their relationships?"

Sex is also viewed as a source of strength and fulfillment that should be explored by clients. This requires the psychologist to create an open, non-judgmental environment to assist the client in fostering their understanding of their own sexual health. Rachel reflected on how sex-positivity uses a holistic approach to promote the exploration and understanding of one's own sexual health:

"I think it's fundamental to wellness, right, and to like to kind of really being like culturally competent too is like understanding if we don't understand our own values around sex how can we like help a client really understand theirs or. And so yeah like being for me like sex positive is like gay affirmative is like, like being like this. It's very much this place of I'm not going to put any of my own cultural messages about sex onto it. We're gonna really explore and figure out what it what it means to you and what you want it to mean to you. So I think that I mean that I think meeting clients where they are is like a fundamental kind of golden rule and I think being sex positive allows you to do that because yeah like if you're sex positive it's not like you're gonna be judging folks who aren't your you're going to be coming at it from a place of assuming this is a source of strength and fulfillment in life and then figuring out how do we help folks explore that."

Rebecca shared a similar experience to Donna in discussing her uncertainty about how to define a sex-positive framework. She was provided with a brief definition and identified her understanding of the term as a wellness approach that aims to help patients maximize their experience with sexual health. Below she discussed how she used her values as a counseling psychologist to orient her understanding of a sex-positive approach. Specifically, she connected her values of a holistic approach that supports an environment of openness for exploration of the client's experiences with sexual health:

"...I tend to think about the whole person instead of just their illness or symptoms. So I guess even in a healthy person it doesn't have any complaints about sex it would be sex would still be relevant because you want to assess for problems you also it could be a coping skill or a help it could be a healthy part of their life that could be maximized it's

not being maximized because they're depressed and just stop trying. You know learned helplessness or something. It could be that just a conversation about it would be helpful to them because maybe they were raised in a place where you don't really talk about it, you know?"

Similar to the other participants, Sonia initially struggled to define a sex-positive framework. She was also provided with a brief definition of the term and identified this as a relevant framework that should align with all psychologists' mission of providing care to clients. Sonia identified sexual health as relevant to the lives of all patients and as one aspect of their holistic identity that would benefit from exploration. She identified the importance of creating an open, non-judgmental environment that incorporates a systematic frame of reference for a client's sexual health:

"...I think to me it's this idea of how do we support family patient families kind of system where they are and while also incorporating all aspects of their life and disregarding that what sex, sexual health in a family's or a patient's life would be disregarding a part of their life experience. Right. So, I think I also believe that like our job is to open up opportunities in an environment in which families and people can talk about anything with no judgment. And I think that would align with this notion of sex positive."

Comfort increased

Similar to their perceived ability, the participants recognized an increase in their level of comfort in addressing sexual health with their clients. All of the participants identified different variables that aided in increasing their level of comfort such as their professional work environment, self-education, professional resources, and support from competent colleagues. Additionally, all of the participants reflected on their continued feelings of discomfort in addressing some topics of sexual health. A review of the participants' experiences with their level of comfort in addressing sexual health issues with clients will be reviewed.

Michelle reflected on how her level of comfort was grown since her earlier years of training. She acknowledged that she is "more comfortable with being uncomfortable" with the

topic of sexual health. Michelle recognized that when discomfort arises with discussing sexual health needs of clients, she finds herself acknowledging this feeling and pushing through the discussion. She also discussed her experience of identifying the meaning of her discomfort and acknowledging this feeling is often reflective of her own biases and experiences with sexual health. However, she stated the more she “habituates” the less discomfort she experiences. She further acknowledged that she believes her discomfort will subside as her professional career continues to develop. Below she reflects on reasons why she believes the feelings of discomfort in discussing sexual health exists; absence of competent training and supervision and the taboo nature of the topic:

“Yeah, I think I am certainly much more comfortable now than there was earlier in my training. And. You know it's funny because I'm It's more like I'm comfortable with being uncomfortable with it. So that like. I think I'm at a stage in my training and I'd be curious to know if this changes for me over time as I get back into clinical work and you know ask me 20 years from now. But like. When I'm asking or inquiring about my client's sex lives and other things pertaining to sexuality like sometimes it feels comfortable for me and sometimes it feels uncomfortable for me and I kind of just push through with that anyway. You know unless I understand it to be like data about what's happening in the relationship or the rapport or something going on the client. Most of the time it's just like my own my own stuff if I'm feeling uncomfortable asking. And the more I've been able to do it like I habituate and the less discomfort I feel and so I kind of wonder you know in 20 years. Will I have any discomfort at all. My guess is no because I think it's just again like not having a good foundation not having a lot of training or supervision around this. You know I'm. I don't always feel like I know what I'm doing and there's discomfort along with that plus, plus just like the content of talking about sex is sometimes that still feels taboo and scary and uncomfortable.”

Donna identified feeling “pretty comfortable” with addressing the sexual health needs of clients. She identified that her level of comfort, similar to her ability, has developed over the course of her professional career. She identified entering into her graduate training during the AIDS crisis as particularly influential in this development due to the increased awareness of a sexual health issue in the public arena:

“I feel pretty comfortable. Probably, because everything comes over time. But being, I guess the AIDS era really wasn't when I was in graduate school, but I was a very early professional when the AIDS crisis hit. And we had an AIDS education committee at Ithaca college, like loads of colleges did at that time, and made flyers, and you know, trained RA's and did all that sort of stuff in terms of encouraging people to practice safe sex practices. So, I was kind of fortunate to have sort of come into the field in that era.”

Donna's level of comfort has also been developed through the assistance of consultation with colleagues, active participation in listservs devoted to sexual health issues, counseling psychology value of cultural context, and professional experiences working with the LGBTQ population:

“Well, talking with colleagues of course. More recently, really active list serves like ISSTD and the ritual abuse one, like I can say this is a common pattern among people who come from, you know, from backgrounds where they were severely harmed sexually as children and involve their extended family. And I don't say for a while and involve a great deal of money because these days, not when my client was a kid, but you know if you have an iPhone and a kid you can make fifty thousand bucks tonight.”

Donna identified that she sometimes experiences discomfort with certain sexual health topics but is engaged in a self-reflective process to work through this discomfort for the benefit of the client. In particular, she reflected on experiencing discomfort with the topic of sex outside of the context of a relationship. She acknowledged this discomfort is related to her personal values and her identity as an adopted person. However, she acknowledged another sexual health topic that initially caused her discomfort, but a personal experience changed her perception. Below she describes her experience of shifting her level of comfort with gay sexuality after the topic became more personal due to her brother “coming out”:

“I think very early on I wasn't as comfortable with gay sexuality. Then my brother came out and that solved that problem. I found that I became an advocate for them. I was, there's a term for it. What is a gay ally, I guess? Yeah. So that's the only thing that I could think of that I grew into.”

Rachel reflected on her experience with increasing comfort as her professional career developed on the west coast. She acknowledged that certain graduate professors encouraged her

to engage in self-reflecting processes by acknowledging personal triggers or biases that might arise when working with clients in general:

“...I think I did in some of my doctoral training like the professors were really great about kind of putting up things that might trigger us like not necessarily, like we didn't get into like open relationships or things like that, but even just like infidelity, or you know, like concepts like that or like what even like the term premarital might mean, you know, like just all of those sorts of things talking about how that kind of shows our biases or shows our expectations. So, they did a really good job of like kind of encouraging humility, encouraging self-exploration, that sort of thing. But I mean really, I think it came through just being, being in my internships and realizing like how, how many clients this was sort of an issue....”

She also attributed her comfort to relocating to a geographical location on the west coast that is more openly accepting of discussing sexual health issues. Rachel reflected on various professional opportunities with networking, resources, and competent supervision in sexual health that resulted from her relocation to the west coast. She also reflected on how the openness of the environment has created a safe space for her to feel comfortable discussing sexual health issues with clients. She reported that she actively attempts to assist clients in developing their relationship and personal comfort with their sexual health. She acknowledged that psychologists are responsible for developing their own sense of comfort with the vocabulary and knowledge of sexual health so they can provide accurate information to their clients. In addition, she suggests that psychologists develop a comfort with the topic in order to engage in sexual health conversations with clients without a reaction. Below she described how psychologists can develop this comfort by acknowledging their discomfort and moving towards the feeling rather than away:

“Anytime I feel like that's our job a psychologist if there's anything that we're like uncomfortable with we're supposed to run towards it to help us be able to hold space for others over there. So just trying, like if you, if you're interested in it like run towards it, like move towards the things that are scary...”

Rebecca reflected on how she feels “pretty comfortable” addressing sexual health needs with clients. She attributed her level of comfort as developing over time, but also due to her personality style. For example, she identified that she is not generally “shy or modest” in her “general personality”. She also reflected on the boundaries of her comfort and certain sexual health topics that she feels more comfortable addressing versus those that result in feeling of discomfort. For example, she discussed how she completes standardized questions for certain military jobs that reflect on sexual health history of pornography or prostitution use. She acknowledged how these topics, especially pornography, is more widely discussed and accepted within the military culture and as a result has aided in her comfort with this topic:

“I feel okay. Pornography doesn't really make me uncomfortable because in the military community it's so just like commonplace people post pornography on the walls people, they have like a specific hard drive they bring on deployment just full of pornography that isn't that doesn't even embarrass me anymore. Talking about masturbation a little bit. I hesitate a little because I don't want to turn them off, I don't want to use that term in the very first session and have them be like what the hell and get embarrassed you know. So that one puts me off a little bit...it makes me more comfortable with it knowing that this is you know pornography and masturbation are something they talk about openly with each other. So, I know that I'm not going to most of them I'm not going to scare them off.”

Rebecca also discussed how she feels comfortable discussing sexual health issues that might arise related to sexual abuse due to the frequency of these conversations with clients throughout her career. On the other hand, she discussed awareness about her discomfort with discussing masturbation or treatment of certain sexual dysfunctions due to concerns about causing discomfort for the client. Below she also reflects on her discomfort and lack of initiation of discussing a client's feelings about their general wellbeing and satisfaction with their sexual health:

“You know, unfortunately, like I said over half of my patients have a history of some type of sexual abuse. So, I'm very comfortable talking about that. I never I never hesitate to talk about that. As far as current sex though, I guess I'm not as comfortable

just saying, how's your current sex life? And are there any concerns with it? I guess I just don't do that until they bring it up.”

Similar to others, Sonia discussed the development of her comfort in addressing sexual health needs of clients over the course of her professional career. She reflected on feeling less comfortable with discussing sexual health issues with clients during her practicum and internship experiences:

“I would probably say I did not talk about it. And some of it was just me. Yeah, I think some of it was because it wasn't a role modeled for me. I think it wasn't integrated as the standard procedure in our service delivery and our information that we gathered from families and so I think I was less comfortable.”

Sonia attributed her increased comfort to an absence of standardized procedure of discussing sexual health with all clients at the onset of treatment or modeling from other professionals. Sonia acknowledged a noticeable increase in comfort upon the onset of her professional career in integrated primary care. Below she reflected on how she feels comfortable discussing sexual health with clients due to the conversation being part of the standard intake in the primary care setting:

“Every patient who completes an initial evaluation over the age of 11 we inquire about their sexual history and drug and alcohol for every patient. It's just standard care within the Geisinger health system. And so, I think asking questions about you know have you ever had sexual intercourse? Have you ever had any sexual acts, have you engaged in any sexual acts? I think it opens up the conversation, we say this is just our standard procedure...I think it just allows for us to have this conversation and in a way that I think wouldn't naturally just happen.”

Sexual health conversations

All of the participants reflected on various sexual health dialogues they have engaged in with clients throughout their professional career. They all identified various sexual health topics they have discussed with clients such as sexual trauma, transgender sexual health, subpopulations, pornography, sexual dysfunctions, sexual wellbeing, etc. The participants

identified sexual health conversations as relevant to their professional work, although some participants identified this as a more prevalent conversation than others. A review of the participants' sexual health discussions with clients will be reviewed.

Michelle reflected on an absence of forward sexual health conversations with clients during her training experiences. Although she established an interest in sexuality and gender concepts during her training, she reported feeling uncomfortable initiating sexual health conversations with clients due to minimal training or competent supervision. She reflected on her clinical training experience at a local VA and an absence of direct conversation about sexual health while exploring clients' sexual trauma. She reflected on wanting to have more "frank conversations" with clients but feeling unsupported in strengthening this skill. Michelle reflected on her feelings of surprise about how she was not discussing sexual health while working for a period primarily with men. Below she reflected on how she felt she was implicitly discussing sexual health in the context of power and relationships:

"So, it didn't come. I think it was conspicuously absent from my V.A. training. And, I think that there's a problem it's probably like a multifaceted set of reasons why that was the case. I think I can say I think this is probably. True. That. I don't think I got good supervision ever about talking about sex or sexual health in any of those settings like another thread of my clinical work has been focused on trauma and PTSD. And even then. It's like. You're not really explicitly talking about sex. I mean you talk about sex in the context of power and relationships. But even just like reclaiming sex or sexual beingness in terms of like the pursuit of pleasure or like being inside one's body like that. I yeah I don't remember ever having I remember like wanting to have like better more frank more informed conversations with supervisors than I ever remember having..."

Donna discussed how sexual health has been prevalent in her clinical work and within her social advocacy. She reflected on her role as a leader on various committees specific to sexual health issues such as the rape education committee, allegations committee for survivors of organized abuse, and active member of trauma informed groups. In regard to her clinical work, she discussed how sexual health conversations have been prevalent since she began her

professional career during the middle of the AIDS crisis. She reported that her conversations focused primarily on sexual health and safety, specifically safe sex practices, during that time. She was also initially involved in the support of providing rape education to university counseling centers and chaired a committee to provide psychoeducation about rape culture and a platform for women to discuss their concerns. She reiterated that regardless of the period she continues to focus sexual conversations through a lens of health and safety:

“...so, I'm working with somebody now who lives in a college apartment with a sweetmate that she doesn't know, and, this sweetmate is bringing men back to the apartment at like 3:00 a.m. The suitemate does not leave the apartment till after midnight and comes back around 3:00 o'clock with different guy every night. And so, then it gets sent to the rights of that sweetmate to have sex with who's she once versus the rights of the person I know who has the right to be safe and not really want strangers in their apartment over and over and over again. So, and also her concern for her suitemate like what is going on and is this really, positive sex? Or is this kind of compulsive? Is this acting out earlier traumas? Like or is this of substance abuse problem, what the heck is going on? So, working with people on communication skills of course continues to be...”

Donna has also explored other sexual health topics, as she has assisted severe incest survivors and survivors of sexual abuse from priests; discussed issue of infertility; aided sex-trafficking survivors in processing their sexual trauma; reflected on affirmative consent in relationships; aided LGBTQ populations in exploring their sexual identity; explored topics relevant to sexual subpopulations; discussed healthy sexual experiences; discussed cultural issues relevant to pregnancy; and engaged in conversations about sex outside of relationships. Donna discussed the relevancy of these conversations with her clients and also her focus in social advocacy commitments. Below she reflected on a recent client experience in addressing sexual intimacy and communication issues:

“...I'm also seeing a man who is an artist and he's I think he's 31, and he is really struggling with intimacy issues. He wants a girlfriend. He's kind of, he slightly identifies without the rage and anger with the in-cell subpopulation. And he sees himself as, as heterosexual. He wants a girlfriend, but he also grew up in this family that was, that saw

sex is very sinful and you couldn't do that and of course then that makes it ever the more titillating but, his, his sexual development mostly came from hardcore porn. So, his images. See I was really trained in negative psychology but, his, his images of what women want to have to do with violence. And so, we've talked about sexual communication and talking with women and also not just necessarily having sex with anybody he feels like because then afterwards he gets really self-critical and doesn't use safe sex techniques and sometimes picks up people that may have health problems, STDs, et cetera. So, so that's another person that I'm working with.”

Similarly, Rachel reported that she frequently engages in sexual health conversations with clients. She reflected on the realization during her internship how prevalent sexual health issues are for clients. She also attributed the prevalence of her sexual health conversations to her focus in sexuality and gender studies, as well as her relocation to the west coast where the topic is more openly discussed with clients. Upon her relocation, she reflected on her experience of recognizing sexual health discussions in the Bay area occurred more openly and often focused on relationship styles, specifically with various subpopulations (i.e. kink, polyamorous, asexual, and BDM). Below she reflected on how her transition to the west coast opened up the conversation of sexual health with clients compared to her experiences on the east coast:

“...You know on the East Coast like I didn't even I didn't even get to the point of being like oh I should learn about this or I should know you know it was like my clients wouldn't bring it up as regularly you know and like you know I would ask about it and you know because I at least knew that right you should inquire about sexual history but like there was a much more like closed offness to it.”

Within these conversations Rachel attempts to guide her clients in exploring their sexual health and to identify how they define their optimal sexual flourishing. Her goal often focuses on helping clients become more comfortable with their sexual health and mindful of their responses to the topic:

“...And we have to do a lot of like they'll still like you know like turn red or like that. And so, so like you know it's like for me it's a lot of like helping them notice like what's coming up for them and developing comfort. So, a lot of like mindfulness sort of things to kind of like recognize that like well yeah what do you think that embarrassment was about or what do you think that like feeling, can you name that feeling? And like really

going pretty slow in that exploration. But I mean even that helps them then be able have those conversations with potential partners and things.”

She reflected on the spectrum of sexual health topics that she frequently discusses with clients such as sexual identity development; exploring internalized themes of ones sexuality; anxiety surrounding pregnancy or inability to achieve orgasm; affirmative consent; sex education; normalizing fantasies; trauma related to sexual health; dating and healthy boundaries; safe sex practices; and combatting shame associated with sex. Below she discussed a sexual health dialogue with a culturally diverse client in which she helped her explore an anxiety response to sex and difficulty achieving orgasm:

“...I had this client, like, she was like a Middle Eastern student...she had this like, para, like a phobia where it like that was around like whenever she would have sex even if she was on the pill and using a condom she was like obsessed that she was pregnant she would take like a million pregnancy tests. But she also had like in our discussion, she was so anxious when having sex like she never had an orgasm. And so, we worked on like you know like I heart female orgasm you know, we looked at all these things. We explored like why she developed that, and she was able to kind of go through stuff.”

Rebecca reflected on how she engages in sexual health conversations when necessary to complete a client assessment for certain government jobs or initiated by a client. She recognized that she often does not inquire about a client’s current sexual functioning and overall sexual health unless they initiate the conversation. She reflected on how certain government jobs require her to ask clients about pornography and prostitution use, masturbation, and sexual encounters with multiple partners to assess for judgment:

“We are pretty good so our assessments of for certain jobs like if you want to be white house security or you want to be an embassy security guard secure our embassies overseas there are certain jobs that we do ask very specifically about pornography use and visiting prostitutes because those are two things that can lead to. It can indicate poor judgment, first of all, and secondly it can contribute to your ability to be coerced or bribed so they won't let anyone do that job if they have significant financial debt because they're vulnerable to bribery or coercion so that there we ask about it. So, like how often are you masturbating? How, do you use pornography every time you masturbate? Is the pornography anything, you know, what is the topic or style of the pornography? And

then sex for money, sex with multiple partners, stranger sex, that gets asked. In my intakes, I honestly don't.”

Rebecca reported that she is comfortable discussing some sexual health topics since they are often related to their veteran status and acceptable topics of conversation within the military culture. Rebecca acknowledged that she also engages in sexual health conversations with clients that have experienced sexual trauma and/or sexual dysfunctions. Below she reflected on specific sexual health topics she might engage in with clients due to the phenomenon’s being viewed more positively and discussed within the military culture:

“Yeah, they're very open in talking about masturbation and pornography. Like I said they'll there's like this phenomenon of a combat jerk which is masturbating after like a really intense firefight. You know you've got all this pent up like just aggression anxiety whatever. So, it's kind of a coping skill for deployed service members. They, they joke about it as far as there's like a certain stall of porta potties on deployment where that's what it's for you know it's for masturbation or they...I don't know that it's the most respectful of other people like I said it could easily offend people the way it's talked about because there's lots of religious people in the military there's lots of people with sexual abuse histories and people who don't want to hear about it. But yeah, they're just super open, but it's not the most respectful of women either if they're talking about having sex. It's not the most respectful, so.”

Sonia reflected on a similar experience to Rebecca with initiating sexual health topics with clients through a standardized assessment. She reported that clients ages 11 and older are asked about sexual health history as part of the standard intake process in the integrated primary setting:

“Every patient who completes an initial evaluation over the age of 11 we inquire about their sexual history and drug and alcohol for every patient. It's just standard care within the Geisinger health system. And so, I think asking questions about you know have you ever had sexual intercourse? Have you ever had any sexual acts, have you engaged in any sexual acts? I think it opens up the conversation, we say this is just our standard procedure and then I think as a result of that if someone says, Yes, right we might say, OK are you using safer sex practices? And then we talk about that which that opens up conversations about how many partners do you have? And I think that it opens up a conversation about what, what do you have female partners? Do you have male partners? How many? How often are you doing this? Are your parents aware, aware? So, and also

just discussing kind of possible long, short- and long-term consequences of having unsafe sexual you know sexually engaging in unsafe sexual acts.”

Sonia also acknowledged that she often refrains from inquiring about general sexual functioning and wellbeing since she primarily assists pediatric clients and their families. She reflected on the complexity and potential boundary issues surrounding confidentiality and condonement if she prompted conversations about general sexual health satisfaction and functioning with her pediatric clients. Her professional foundation has supported sexual health conversations with clients about safe sex practices, sexually transmitted infections, relationship configurations, intimacy issues, transgender care, and sexual health issues that incorporate pediatric and family dynamics. Further, she discussed how she encourages her supervisees to engage in sexual health dialogues with clients and provide psychoeducation and/or dig deeper than the standardized intake about sexual health needs if necessary, for the wellbeing of the client. Below she reflected on a particular pediatric client that she assisted and the complex nature of evaluating the systemic influences that might be present when addressing sexual health issues with culturally diverse pediatric clients:

“...the patient is like a 10-year-old kid and he is having intrusive images and thoughts about sexual things. And so, you know it's complicated because he's 10 and so one thing that I really made sure to do is really understand the family culture around these conversations. So, what conversations do families have around this? Where are kids getting it? Where are the kids that I'm working with getting knowledge about, you know, anything related to sexual health? Are they getting it from school or are they getting it from friends or are they getting from online, parents, extended family members? But also, really understanding the kind of family's perspective and view of sexual health and discussions of sexual health.”

Guiding Question #4: What experiences have counseling psychologists had with sexual health training within their graduate programs and outside of their programs?

The themes developed from this guiding question reflected the participants' experiences with sexual health training in their graduate training and professional opportunities outside of

their training program. The participants all reflected on an absence of sexual health training from their graduate training and within professional opportunities. They all felt sexual health training in their graduate training would have benefited their sexual health competency and comfort in addressing sexual health issues with clients. Lastly, they all provided educational and training suggestions that could assist graduate students in their development of sexual health competency. The themes developed from this guiding question were *absence of training and supervision, absence of continuing education, and educational suggestions*. This section will highlight potential improvements for graduate training programs to prepare trainees to become competent in sexual health. The experiences of all the participants will be reviewed and suggest a general absence of sexual health training and support from graduate programs.

Absence of training and supervision

All of the participants reflected on their experiences with an absence of sexual health training in their graduate programs. Although a couple of the participants reported they “might” have engaged class dialogues about sexual health issues, they were unable to identify any specific conversations that occurred. Further, most of the participants reported there was an absence of sexual health training or dialogue in their practicum and internship placements. A review of the participants’ graduate training experiences with sexual health will be reviewed. Also, two of the participants spoke directly to an absence of competent supervision for sexual health topics during their graduate training. A review of the two participants’ experiences with supervision in sexual health during their graduate training will also be discussed.

Michelle recognized an absence of foundational sexual health training throughout her graduate training experience. She reflected on how she believes graduate training programs approach training through an “older positivistic attitude” that is reluctant to incorporate topics of

sex, religion, and politics into dialogues with clients. She reported that she faintly remembers a presentation from a visiting faculty member that discussed her interest of sexual health and non-traditional relationships. However, she recognized this to be a “side-bar conversation” that was not congruent with the topics being discussed in the course at the time. Additionally, she discussed her experience with an optional gender and sexuality seminar that primarily focused on identity development and identity politics. She acknowledged the course lacked specific material about sexual health topics:

“I do remember there was we had a visiting faculty person at my university who this like sex and sexual health and, and, and also non-traditional relationships like polyamory that was sort of a pet interest of hers. And I remember like her saying if you find anybody who's really good at providing supervision on sex like learn everything you can because it's generally an area that will just get ignored in didactic training and getting nowhere in clinical training. And like so I became I, I made her into like a friend and we're still friends and colleagues and because I felt like she was that person. It wasn't. It wasn't from a lack of interest of mine. I mean sex and sexuality have long and gender stuff had long been interest in mine. But I it didn't seem like there was a lot of helpful conversation happening in clinical settings about it.”

Currently, she is involved in academia and denied any knowledge of sexual health related courses or trainings available in the department. As a faculty supervisor, she often refers students to clinical literature or APA relevant guidelines about transgender healthcare or other related topics. Below she reflected on the sexual health training opportunities that were available during her graduate training:

“The only times I remember talking about it are with the visiting faculty person that I mentioned, and that wasn't it because like we read something about it, it wasn't like the topic of it wasn't like in the syllabus. It was just sort of a sidebar conversation. And then I also took an, an optional seminar in gender and sexuality but that was much more focused on pop like identity politics and identity development models. And then I mean it was a great class. I loved it but we didn't talk about sex.”

Michelle also reflected on the absence of competent supervision for sexual health topics during her graduate training. She remembered wanting to have more “frank conversations” with

supervisors but not feeling comfortable to initiate the conversation. Further, she reflected on how the dynamic of identities that was present between her and male supervisors also resulted in difficulties for her broaching the conversation with male supervisors. Michelle also spoke about how an absence of competent supervision impacted her competence and comfort in addressing sexual health issues with clients. She reported that modeling on how to initiate sexual health conversations with clients from a competent supervisor would have been helpful for her training development:

“I don't think I got good supervision ever about talking about sex or sexual health in any of those settings like another thread of my clinical work has been focused on trauma and PTSD. And even then. It's like. You're not really explicitly talking about sex. I mean you talk about sex in the context of power and relationships. But even just like reclaiming sex or sexual beingness in terms of like the pursuit of pleasure or like being inside one's body like that. I yeah I don't remember ever having I remember like wanting to have like better more frank more informed conversations with supervisors than I ever remember having...”

Donna discussed her experience of being trained during an era when sexual health discussions were approached from a “sex negative” framework that focused on educating people about ways that sex can be harmful. For example, she discussed how her professional training occurred during the AIDS crisis while she was pursuing clinical work in university counseling centers. During this time, she trained resident assistants and provided psychoeducational material to the campuses about safe sex practices:

“Well I don't think I was ever taught anything. I was never taught that sex, sex was negative. I never was taught anything about sex being shameful nor did I feel it. I mean we came straight out of the 70s liberation generation. But, I'm more aware of the negative things that can happen...When I was in graduate school. Well I've given trainings, but I don't think I've actually been to any because that was kind of early in the process. And we would you know we gather materials that other counseling centers and health centers were using, and we would modify them for our population.”

However, outside of this dialogue she was unable to recall any specific courses or dialogues within her graduate training that focused on sexual health. She acknowledged there

was an absence of general conversation or focus on sexual health topics within her training. She did not reflect on or discuss any experience with supervision during her graduate training.

Below she reflected on the absence of sexual health training in her graduate program and attributed this to the era she received her training:

“There were no classes. There were no explicit...I don't have any explicit memories that you know when we did roll plays in introductory counseling. Certainly, when I was in practica that those issues weren't shied away from. But in terms of stuff that involved a syllabus and you know particular readings, no there was nothing. From 1976 to 1982 which shouldn't come as a surprise to anybody.”

Rachel discussed the absence of sexual health training in her graduate program on the East Coast. She reflected on her experience of recognizing her absence of sexual health training upon her relocation to the West Coast. She emphasized the role geographical location played on her incomplete training and how geography shaped the types of sexual health conversation she engaged in with clients. For example, she discussed her experience of exploring sexual identity development with clients on the East Coast as focused primarily on safety while those on the West Coast have more openly expressed their sexual identity and explored various relational configurations:

“...coming to the Bay Area, there is, they're like so my training was in the East Coast, and then I came out to the Bay Area where I still am for school, and a big part of kind of sexual health had to do with like learning more about and understanding like poly communities and kink communities out here. And so that was a big shift for me, I feel like that was never even talked about in any of my training in the East Coast and coming out here is like oh yeah I need to know, like I need to really understand what I like, why I just thought monogamy was what everyone did because that was all anyone ever talked about and like really examining that...”

Rachel also tied these differences to state licensure requirements, as some states on the West Coast require human sexuality training to obtain licensure as a psychologist. She acknowledged that she has engaged in self-education as a result of the absence of sexual health training in her graduate program:

“In California there's a requirement for your license you have to have training in human sexuality which is cool. And so I did have to take it like I took that required class when I got here before but that required class was horrible like there was this one online version that I had like I didn't quite say this because basic like the uterus is a baby cave, you know, it was like all about sexual, like that women sexuality exists just for procreation. It was like what is this crap? I was super fortunate like that I mean again like working with the queer community there's just a lot that like you need to know or understand in order to be effective with that but then also like I was really fortunate. One of my colleagues she was doing her predoc while I was doing my postdoc. She's amazing and was like a sexual health educator. And so, she did presentations for us on sex therapy and so like they brought in folks who did seminars on sex therapy and I'm looking at these things. We had good folks we could refer to and consult with. And so, then like of course she's always my go to with like okay what's the book that I can read. What's the bibliotherapy that we can use here what are the things that we can bring in to have this happen. But I definitely had to do a lot of my own stuff for that.”

In regard to specific sexual health training, Rachel acknowledged an absence of related courses or dialogues within her courses. She reported that conversations about sexual health occurred “very minimally” and might have been present in her couples and family or internship class. She reflected on how she received substantial support during her internship due to her relocation and internship placement at a sex positive center. She discussed her awareness of uncertainty about how she would have gained this training if she did not complete her internship at the site. Below she reflected on the absence of sexual health dialogue throughout her graduate training and the unavailability of one course that was offered in human sexuality:

“...I definitely feel like I didn't get enough training in it like in, in grad school it was not a clear focus. I think I've had to do a lot of training since then. Like there was one human sexuality class you could take as an elective during my grad program but in the five years I was there it was offered only one time and it conflicted with internships so I couldn't take it.”

On the other hand, Rachel discussed appreciation for her graduate training program incorporating self-reflective practices of her biases and values on potentially triggering terms such as premarital or infidelity. Although the conversations were not directly related to sexual

health, she discussed how their encouragement to reflect on her biases was helpful when she later engaged in challenging sexual health dialogues with clients:

“...Yeah I mean I think I did in some of my doctoral training like the professors were really great about kind of putting up things that might trigger us like not necessarily, like we didn't get into like open relationships or things like that, but even just like infidelity, or you know, like concepts like that or like what even like the term premarital might mean, you know, like just all of those sorts of things talking about how that kind of shows our biases or shows our expectations. So, they did a really good job of like kind of encouraging humility, encouraging self-exploration, that sort of thing.”

Rachel also discussed an absence of competent supervision within her clinical experiences during her graduate training. She felt that her supervisors held a similar training ability to her as a student in addressing sexual health issues with clients. She discussed that even as a professional psychologist, she continues to feel that she does not have adequate supervision on this topic. Rebecca acknowledged that competent supervision will continue to be rare if training programs are not helping build this competency for students:

“...the skills part is hard, like I often like the way that I handle like I don't really have a supervisor that I can go to and say like you know what about this. ...I don't, I guess I don't have a very clear definition of competency. I do know there's ways that I wish that I had access to more supervision around these things in practice, but a lot of my supervisors weren't necessarily, didn't necessarily know more about it than I did, and so it's hard to, yeah, balance that.”

Similar to the experiences of the other participants, Rebecca discussed an absence of sexual health training in her graduate training. She acknowledged that she did not have any sexual health specific courses and was unable to recall any lectures or class dialogues that occurred about the topic. Rebecca reported that if she would have discussed the topic it would have occurred during her clinical placements when a client identified a sexual health issue. Below she reflected on awareness of the absence of training in her graduate training as she moved through the interview process, but acknowledges she seeks support from others if she engages with a client's sexual need that is unfamiliar:

“I guess it definitely could've been better no question, with your questions I'm realizing I haven't had any formal training... I'm sure something came up. And I definitely consult about it. You know because this is something most of us don't have specific training in, so I'll definitely ask somebody if I'm into a sexual topic. We talked about it once as far as privileging it's come up for that because all of us LCSW's and psychologists we all have a no on privileges under formal sex therapy. And so, it came up for that purpose which I wouldn't want to do formal sex therapy anyways assuming I understand what that means. Nobody is doing that anyway, but then one of our LCSW's received a consult that was for premature ejaculation or some sexual thing and he declined to take it. He sent it to one of us because he said his state does not allow him to do sex therapy. But to me that's not sex therapy anyway that was it's a different thing. But I remember having that conversation related to privileging.”

Sonia similarly discussed her experience with an absence of sexual health training in her graduate training. As she progressed through the interview, she discussed feeling “sad” about her awareness of insufficient training in sexual health throughout her graduate training. She reported that she did not take any specific courses related to sexual health and has vague recollection if the topic was discussed within her courses. She stated that she “might” have discussed the topic in their life span development class, but she is not completely confident that occurred. She reflected on how she was introduced to sexual health issues in her graduate training through her clinical work with pediatric patients, primarily with kids on the autism spectrum. The quote below reflected her experience of recognizing an absence of sexual health training and that conversations most likely were client specific during supervision:

“I think we might have talked about sexual development. We might have talked about. I think it mostly came up in individual supervision cases that I can remember when specifically talking about a patient or family...We might have some in development in like our life span development class we may have talked a little bit about it but other than that I can't remember specifically talking about and learning about sexual health.”

Sonia reflected on her current role as a supervisor in a primary care setting and reflected on how she often educates her trainees on the importance of creating a safe space for clients to expand on their sexual health history during an intake. She also reported that she encourages her trainees to provide psychoeducation to patients about sexual health when needed:

“I educate all of my trainees right. So, to me it's like OK this is something that I didn't have training in. And well we have to talk about this. And so, in intake I, I whenever I read anybody, I supervise they'll be like, yes because it says like sexual activity and it says yes and I'm like that doesn't tell me anything. I do not ever want to just see a yes. I want you to say things like this person is currently involved in a romantic relationship of blah, blah, blah years, with a male or female partner or whatever. They are currently using or not using safer sex practices. How many sexual partners have they had? I want you to elaborate. This is not a yes or no question. And I have one of my trainees who actually interned for me earlier would like so how appropriate is it for me to talk about STI's with the patient that is sexually active? I was like, very appropriate, very appropriate, you should bring it up. You should bring it up, you should provide education about it. They were like, Oh OK. And she fortunately worked at an agency that that's what they did. So, she's even more well suited to talk about it. And so, I said, this is an area that you're an expert in and your job and my job is you know as providers of behavioral health providers is to impart knowledge and education to increase people's awareness of all factors when they make a decision. “

Sonia also reflected on her experiences with supervision during her graduate training and did not recall the conversations being of particular usefulness in addressing sexual health needs of clients. Instead, she acknowledged the process of experiential learning to be most helpful since she perceived limited support from her training program:

“I don't think any my supervisors technically did. I think some of it, it was like kind of being thrown at the deep end of the pool with no floaties and just like had to figure out how to swim like it was. And I think it just kind of came with and with just experience honestly and just observing how our doctors do it and learning about how to use patient centered language but then also training our pediatricians and just and just making sure we're as a whole doing similar kind of similar kind of methods to providing better care.

Absence of continuing education

Most of the participants acknowledged an absence of available professional continuing education or training opportunities about sexual health topics. All of them acknowledged the utility of such opportunities in helping them build their competency in sexual health to best assist clients. Although many of the participants did not have knowledge of professional continuing education training opportunities, many of them discussed ways they continued to obtain training in sexual health for their professional development such as consultation with competent

colleagues, obtaining relevant reading material, and being involved in professional groups. A review of the participants' experiences with sexual health continuing education opportunities and trainings will be reviewed.

Michelle acknowledged an absence of continuing education opportunities specific to sexual health topics. She reflected on how she has gained some knowledge about transgender care from her work with a research hospital. She recognized this opportunity as a “backdoor” resource to engage in professional gender and sexuality conversations from a biopsychosocial framework. Additionally, she reflected on her personal interest in gender and sexuality issues has been motivation for her to pursue continuing education through reading relevant material and sitting on a consultation team, so she is able to engage in sexual health conversations with competent colleagues. Below she reflected on her experience as a faculty member in referring students to relevant literature that promotes independent continuing education in sexual health:

“...You know I think one of the interesting like there's a lot of interesting and useful things that have arisen because of trans health movements right now and that's one of them. I mean. Like we have a lot. We have a partnership with. A huge. One of one of the largest national research hospitals that provides all kinds of treatment and services for trans youth in particular. And it's kind of been like this backdoor way into having to talk about gender identity, sexuality, and sexual health and from like a biopsychosocial model. And so, I think that's probably where we have a lot of students who do training there. So, I think that's probably where it comes up the most. But usually like my role as like faculty supervisor in those experiences is to like students don't know that you know that APA just released the new clinical guidelines for working with trans and gender nonconforming folks. So, like that's usually my role is to connect them with like clinical literature sometimes research that mostly clinical literature on working with trans folks and so again I'm not really talking about sex or sexuality. And I think that actually could be an area where. There. Because again it's they're working within a medical model like a medical context. And so, if I were if I were if I were providing some of those conversations about like so how do you talk to trans clients about sex that could actually be really useful.”

Similarly, Donna acknowledged an absence of professional continuing education opportunities about sexual health topics. However, she discussed how she provided professional

training opportunities to others when she worked in university counseling centers. She reflected on how she assisted in training resident assistants and provided information about safe sex practices to students on university campuses. She also continues to obtain educational information through her involvement in professional organizations and as a member of an allegations committee that introduced her to information on victims of organized abuse. Donna also remains active on professional listservs related to sexual health topics, obtains relevant reading material, and systemically remains involved in creating awareness for issues such as low validation of sexual abuse claims within her community. Below she reflected on how she has not attended any professional continuing education opportunities but has aided in providing them for other professionals:

“Well I've given trainings, but I don't think I've actually been to any...kind of early in the process we would you know we gather materials that other counseling centers and health centers were using, and we would modify them for our population.”

Rachel reflected on various continuing education opportunities she has been given while residing on the West Coast. She reflected on the role that her transition to the west coast has made on her overall level of training and uncertainty of how she would have developed this skill otherwise:

“...But then again like my experience at Cal in my predoc and postdoc there was a lot of opportunity for that. But I had a lot to do with my, my cohort members. And then also just being on a campus that had like they have peer sexual health educators at Cal. And so, they came in and gave a talk to us to or was like, yeah. So that was just a really like sex positive center. And so, I think that helped. So, I, but I mean if I hadn't ended up at Cal I don't know if I would have been able to move forward with all of that or get the training that I did.”

She identified that she has attended continuing education trainings on open relationships, sex therapy, and sexual aversion. Additionally, she reported that she is an active member of a local professional organization that supports psychotherapists and students in consulting and

networking about sexual health topics. Through this opportunity she is able to consult with knowledgeable colleagues, two of which are certified sex therapists, and is provided with useful information on sexual health topics. She also recognizes the utility of bibliotherapy and often receives suggestions from colleagues that are knowledgeable in sexual health and continues to stay up to date on relevant professional guidelines. Below she reflected on her experience in the local professional organization and its mission to provide support and ongoing dialogue about sexual health:

“...I'm a member of this organization called Bay Area Open Minds where it's a big association of mental health professionals that are all committed to being pro poly, pro kink, you know, like we're very supportive of that and able to help folks in figuring out what's the configuration that works best for me and what are the issues that kind of come up within an open relationship...And then also like being part of Bay Area Open Minds has been helpful, being able to go to continuing education on open relationships, poly, like, but also like sexual aversion.”

Rebecca identified one professional continuing education opportunity that was offered through her employer, and she attended, for transgender healthcare. She reported that she has not avoided sexual health trainings but has not been offered them. However, she spoke in length about how sexual health trainings would be useful for her professional development and helpful in identifying ways she could incorporate sexual health into her intake process or treatment plans. Additionally, she identified sexual health trainings that provided information on issues specific to veterans assist her as a military psychologist. Below she reflected on a specific sexual health training that would be helpful for her role as a military psychologist:

“If it were specific to military, I would love that because there's so much ED [erectile dysfunction] with the like I said the PTSD guys in depression. I mean even the ones that aren't taking meds they have that's very common. So, I would love that. It's like common sexual treatments for in therapy for military service members would be awesome.”

Sonia also recognized an absence of continuing education or training opportunities about sexual health. She briefly discussed how she will consult with other professionals at times given she practices in an integrated primary care setting. However, she did not reflect any further on her experience with training or extended education opportunities with sexual health. Below she reflected on her unfamiliarity with attendance or occurrence with any sexual health continuing education opportunities:

“No, no not that I have not that I have taken or seen specifically.”

Educational suggestions

The final theme developed from this guiding question was educational suggestions provided by all of the participants. All of the participants identified suggestions they felt would aid future graduate training in better supporting students’ sexual health competency. The participants’ responses incorporated suggestions that would build upon the core foundations of a trainees’ knowledge, awareness, and skills in sexual health. The foundation of these components would further aid the ability and level of comfort for trainees to better assist their clients. The participants’ responses ranged from encouraging self-reflective practices, providing knowledge on specific sexual health topics, providing opportunities for role play and modeling, and creating a space for active dialogues amongst students and training faculty to occur. The participants’ educational suggestions for graduate training will be reviewed.

Michelle reflected on her experience feeling uncomfortable and unprepared in assisting clients with their sexual health needs. She spoke in detail about how she attributed these feelings to her lack of training in graduate school. Michelle identified that a “sex seminar” would have been useful in helping trainees prepare for sexual health discussions with clients. She discussed how this seminar could provide an opportunity to educate trainees on sexual health knowledge but also modeling opportunities by a competent supervisor of relevant clinical skills. The goal

would be for trainees to have an opportunity to put their skills into practice with the guidance of a competent supervisor:

“Yes, a seminar in sex. A sex seminar. I mean it would be such a goal. And now as an instructor like that would be a cool class to develop and teach but like yes, a seminar about sex and sexuality and sexual health. I mean you could. There's a lot of ground to cover. Like you could definitely have an entire seminar just devoted to that. And. And then and I think maybe making you know half of the class sort of content or knowledge specific and then half of the class like clinical skills. That would have been great.”

Additionally, she spoke about the importance of trainees engaging in self-reflective practices to gain awareness of the values they place on sexual health. Below she identified a “best practices” model that she feels would incorporate sexual health knowledge, awareness, and skills into graduate training:

“...I think a best practice in this is based on my own reading of the training literature and my own experiences both as a trainee and as trainer. I think having a supervised field placement experience in sex and sexual health. And I think you don't need a specific setting to do that and you don't need a specific population you just need a competent supervisor to ask the questions...And to and to model the interactions and what they can look like...Like you know eight times out of ten like it would be in there somewhere and these clients I think as a result would just get that much better therapy or treatment if they were being supervised by somebody.”

Michelle also discussed her role as an educator and referenced ways that she attempts to encourage openness about the topic of sexual health amongst her trainees. Specifically, she reflected on the importance of encouraging self-reflection and conceptualization of sexual health. Through the reflection of her experiences as an educator, educational suggestions were provided, such as incorporating the competency foundations into current educational practices:

“I just read like 10 doctoral students getting ready to take comps they wrote like a practice case conceptualization paper and they told me this was all really helpful. But like I and like I really pushed them to think more deeply and critically not only about like awareness stuff around multicultural responsivity but like, like in practice what does that look like so that like in because in some you even in their writing like the way that they talk about sex. Or the things that they totally leave out of their conceptualization. I was like you got you're really missing some stuff here you really got to think through that like equating. Like talking about sex. Like not using the word sex and instead using like

romantic relationships. That's like no that's not what your client's talking about. Those things, sex can happen outside of a relationship it's not only true of romantic relationships. So, stuff like that.”

Donna identified the process of preparing trainees to be competent in sexual health is a value based, attitudinal process rather than a curriculum. For example, she reflected on how working with clients from different backgrounds is the best way to assist trainees with sexual health competency. She discussed her experience of working with multicultural clients and the importance of engaging in self-reflective processes about her own values to avoid projecting them onto her clients:

“You know it's something that so personal and values based that it's almost doesn't feel to me like a curriculum. It feels like, like I'd be prone if I was going to set up a system to use the strength of trainees which is their wish to help people and connect with people. I think I might be a little bit more indirect about it regarding assignment of patients. So that it's about real people and not about me even this late in my life like not about images of a thousand people having sex on the side of a river which honestly still creeps me out. But, but like sort of leading sometimes leading with the broad social issues or the facts and figures. I think more it's more attitudinal and so working with clients who are different than you would be something that if I was in a training position that I would be prone to want practicum students to do.”

She also suggested that training programs incorporate opportunities for role-playing sexual health conversations and a space to have a dialogue about the topic. Donna also discussed the relevancy of being familiar with terminology and relevant social issues that might be impacting clients' sexual health:

“...we talk about knowledge, attitudes, and skills right, in terms of competencies, so certainly knowledge is needed about the issues of the day, really. You know if those issues include child trafficking patterns in your community or knowledge about how AIDS is transmitted or knowledge about, knowledge about positive sexual interactions and the ability to say no and what does full consent mean.”

Rachel identified creating a space for dialogue about sexual health as an important tool to assist graduate trainees with sexual health competency. She discussed how her sexual health competency was gained through self-educational practices of seeking resources individually.

She highlighted the importance of students gaining exposure to the topic of sexual health to assist with their competency with this phenomenon:

“Yeah, I mean I think a big part of it is just like exposure to it, right? Because there is this like, you know, sometimes when I bring it up with students there's like giggles or you know I'm like are we in middle school, like what's happening? You know again like recognizing how little sex education is out there especially like we went under Bush there were 8 years of abstinence only being promoted. Right. And then we have like a nice little oh 8 years where maybe some of the students coming in had something a little better. But even during that like parents could always opt out. So I think like maybe just as acknowledging that like all of our client, all of our students are going to come with like maybe no background and maybe no knowledge in this and like figuring out like just starting to have those conversations in a professional space is important to help people develop that comfort and to like notice what's coming up. Notice your emotional responses and then go talk to your therapist about it figure out like what is going on here. But yeah definitely a strong encouragement for moving towards those topics and developing that comfort.”

Similar to Michelle, she discussed the utility of building an “intentional model” for training programs to identify ways trainees can gain sexual health competency within their coursework and through clinical practicum and internship sites. Rachel reflected on the need for competent supervisors to exist at the clinical sites to assist students in building relevant skills. She also suggested incorporating the information into different classes, such as the couples and family class, that already exist in the event that additional courses are unable to be added to the curriculum. This intentional model would also encourage trainees to engage in self-reflective practices of their own values and biases about sexual health. Training programs could further promote this by encouraging trainees to explore their discomfort with certain topics:

“...I definitely, I think like at internship sites it's, I think it's important for that to like, like the supervisor level for that to be there but right we can't have those supervisors unless there's something probably happening in schools. And so maybe as part of like internship or practicum courses having that be an intentional model. It's hard to like you could add on another class but there's already so many classes that a psychologist has to take. And then you know I do like that California has the required that you have...Like I so I train MFT's right now and they do have a full class that's, that they take on human sexual, that's like sex therapy learning about all these different things and so I do see that as super useful. I just don't know what you take out to put that in within a training program.

So I do think maybe it's like changing the way that we teach though like couples and family class or changing the way even that you can find it to couples and family it kind of says like this should be a thing that happens in couples and families it's not necessarily this broader so yeah it's not a good answer but I'm all over the place with it.”

Rachel reflected on how this could be implemented on a macro level by adjusting accreditation standards to promote this as a standard of the field. Additionally, encouraging an increase in conversation within professional organizations such as APA’s Division 17 or at relevant multicultural conferences. She suggested using these as platforms to encourage and recommend relevant reading material or availability of sexual health training webinars. She also suggested building a special interest group within these organizations that can help create sex-positive research and build the foundation for other professionals:

“Yeah I feel like the TCP special issue was really helpful and like starting a conversation and I guess it part of my seeking out training was like a lot of those authors gave presentations at multicultural summit and so I think like having folks like kind of try to take over some of these things really bring that bring this conversation do bring this into the awareness maybe even having like a special interest group in 2017 that's about this could be helpful right to just like then at least like sex would be on the website. You know like those sorts of things so getting like a critical mass of folks together that are addressing this would be really helpful.”

Further, Rachel discussed the importance of encouraging professionals in the field to be aware and curious of issues that cause them discomfort and then create a space to engage in active dialogue with other professionals about those feelings:

“Anytime I feel like that's our job a psychologist if there's anything that we're like uncomfortable with we're supposed to run towards it to help us be able to hold space for others over there. So just trying, like if you, if you're interested in it like run towards it, like move towards the things that are scary and so I guess encouraging that.”

Rebecca primarily reflected on ways to incorporate educational opportunities into the professional field for practicing psychologists that would also be relevant to trainees. For example, she discussed the utility of increasing training opportunities that would inform psychologists on how to incorporate sexual health into the intake process or treatment planning.

She also reflected on the benefit of having frequent trainings from experts on sexual health topics that are specific to veterans. Rebecca also spoke to the usefulness of creating a space for professional dialogue to occur about sexual health within graduate training programs.

Specifically, she discussed the benefit of creating a group consultation that would allow her to gain knowledge about how peers are initiating sexual health conversations and how they are creating a safe space for their clients. Below she reflected on how professionals would benefit from gaining knowledge of the current literature and relevancy of certain sexual health topics:

“I guess maybe current statistics or research about what is the most common thing they're not telling us about sex that maybe we should bring up. So certainly pornography addiction I guarantee ten times as many people that have told me about that are actually experiencing that and a lot of times I hear about it actually through the spouse like the spouse will be my patient telling me that one of their major problems is their spouses pornography use, but that guy's not telling anybody about...”

Sonia reflected on the utility of educating graduate trainees on how to engage in difficult conversations with clients. Specifically, trainees would benefit from interviewing skills to help clients have sexual health conversations more naturally:

“I think being able to I think it could be incorporated into having a difficult conversation. Like how, how do you bring up conversations about things that aren't that maybe aren't what, what, what some patients and families might believe is outside of the scope of a psychologist practice. Right. So, there's lots of things right. So, I think how do you have difficult conversations with families when we know that there are so many cultural components or factors that might that might impact conversations about drug and alcohol but also sexual health. Right. So, I think how do you navigate those things would be a probably good thing because the reality is there is going to be complicated situations that happened across all people we work with in this field.”

Additionally, helping trainees understand how to provide education to clients without condoning or projecting their biases or values onto the client while also considering the client's cultural background and context. Sonia reflected on how her competency was formed primarily through the process of evaluation and modeling from supervisors at her clinical sites. She discussed how others modeled sexual health conversations and the importance of recognizing

client verbal and nonverbal reactions during those conversations. These experiences also aided her in identifying ways to challenge client reactions to sexual health conversations and ways to use inclusive language that is relevant to the client's experience. Similar to other participants, she reflected on the importance of exposure to sexual health conversations within graduate courses to help trainees prepare for translation of the skills into practice during practicum and internship:

“Yeah, I think in some ways you know some of these skills kind of you can learn them in class you can learn about it. I really think where it can be it is hard because unless you are actually practicing it it's hard to translate what you learn in books and what you learn in class to really translate to the actual treatment that you're doing in the room...I guess clinical skills training that we get during grad school they might talk about how you might also introduce or discuss sexual health. Right. So maybe that needs to be introduced in grad school. But then when you're on internship you're talking about intakes and appropriate questions that we're really incorporating that in there.”

Guiding Question #5: What role does the counseling psychologists' personal values play in assisting clients with their sexual health?

The primary theme developed from this guiding question reflected the participants' experiences with their personal identities and values in addressing sexual health needs of clients. The theme developed was *relevance of personal identities and values*. All of the participants identified specific values and/or identities that were salient in their role as a psychologist. They discussed the importance of engaging in self-reflective processes about their values in order to gain awareness to avoid projection onto the clients. The participants' experiences with their personal identities and values and their relation to addressing sexual health needs of clients will be reviewed.

Relevance of personal identities and values

All of the participants reflected on personal identities and/or values they felt were important to recognize when considering sexual health needs of clients. They discussed their

processes of gaining awareness of how these identities and/or values are important to reflect upon to avoid projecting them onto clients. Participants explored their relationship to various identities such as their sexual orientation, gender, professional, racial, and ethnic. Additionally, they explore their personal values of their own sexual health, religious beliefs, and generational values. A review of the participants' identities and values as they relate to their process of addressing client sexual health needs will be reviewed.

Michelle discussed the importance of engaging in a critically self-reflective process of one's own worldview and values. She described how this can be useful in helping the psychologist identify the values that can be helpful in them connecting to clients or potentially disruptive in connecting with clients. She believes that psychologists should reflectively acknowledge all facets of their background and identities during this process. Further, acknowledging what these values might portray to clients and how they might interact with the client when discussing sexual health. She also discussed her experience of encouraging her students to be multiculturally responsive by understanding how their cultural backgrounds interact with those of the client.

Michelle acknowledged various identities that she felt might be influential in her general interactions with clients. For example, she reflected on her identity as a white, queer, woman that is a consumer of knowledge and professional in the field of psychology. She also discussed the role that her identity as a sex-positive feminist and social justice advocate has on her connection with this topic and passion for helping clients explore their sexual health needs. Michelle discussed her role as an educator and researcher in which she uses these identities to impart sexual health knowledge and skills onto future psychologists. Lastly, she reflected on

how her own journey with sexual health and relationships and how they can be influential and interact with all of her before mentioned identities:

“...I think as I well I think this is when I can say that like my I've certainly had my own journey around sex and, and relationships... I mean it's one of the reasons why I like being a psychologist as an incredible fit for me professionally because your own growth in your own journey are then reflected in your teaching and your research and your clinical work.”

Michelle also acknowledged how her identity as a young woman caused disruption with initiating educational conversations about her clients' sexual health needs with her male supervisor. She briefly discussed how the interaction of identities with other colleagues and supervisors can collude to disrupt an educational dialogue opportunity about sexual health. Therefore, this further expands on how one's personal identities can indirectly impact the care and needs of clients:

“...And then the added layer of being a young white woman working primarily with African-American male veterans. So, so not only like the gender piece but also the racialized piece around our respective identities and sex and sexuality. I think it was really. I think it was. My hypothesis is that it was fraught that there were a lot of dynamics happening below the surface and like that came out in different ways. But like. How helpful would it have been to feel more competent and confident in addressing sex and sexuality, especially in in therapeutic relationships where there was a lot happening in terms of our own intersecting identities.”

Donna reflected on various identities and cultural factors that influence her relationship to the topic of sexual health. She spoke directly to her experience as an early career psychologist during the 70s liberation and how generational values has shaped her understanding of sexual health. For example, she discussed how early in her career there was more focus on “fear of being pregnant” and rape education. Donna also discussed how she feels her generation is more private about their sexual experiences. She reflected on how her age and identities as a feminist, white woman has also influenced how she discusses sexual health with clients of varying racial/ethnic identities and from different generations. She discussed how she feels “more

cautious” discussing certain topics with younger clients, as she does not want them to perceive her as being motherly. Further, she discussed how this is also important for her to reflect on given that she identifies as a mother too. Donna acknowledged that she feels her identity as a counseling psychologist aids in her being more aware and transparent about all of these identities.

Donna reported that she was raised in a Catholic tradition and serves on an allegations committee. She reflected on how her religious beliefs and her position within the church as a committee member could influence her perceptions of sexual health. The identity that she described as being the most influential in shaping her understanding of sexual health is her identity as an adopted person:

“Oh, that's a really good question I never thought of that before, but I think probably the biggest shaper of that is being an adopted person...Because my birth mom was pregnant outside of wedlock in 1954, was sent away as women were prone to do based on cultural traditions at the time. Hundreds of thousands of children were sent to orphanages because of the sexual shame involved in not being married or translated to current day standards not being in a relationship not having two parents. I met her when I was 28 and stayed in a close relationship with her and my birth father until they died. They got married and had seven more kids. So, I'm the oldest of a family of eight. My, my brother, who actually knew a lot of counseling psychologists when he was an RA at Irvine. Anyways he's just one year younger than me and then it's boom, boom, boom sort of Irish Catholic cultural pattern. But she told me the story, with great pain, of when, so all these girls, she was 24, wasn't a kid all these but, but nobody was married, and it was in Minnesota, but it was happening all over the place and certainly wasn't limited geographically at that time. So, they were in a home for unwed mothers for from the time they learned they from the time they were showing until the time they delivered their baby. It was, babies were marketed really. These mothers were viewed as cultural pariahs and their babies, were, they it was, one of the things we wrote about in our article on counseling with birth mothers was the difference between legal voluntary surrender and emotional voluntary surrender. It was not voluntary. It was like sign this paper you person with no power.”

Donna also reflected on how she values sex within the context of relationships attributed this to knowledge about her mother being pregnant out of wedlock. She reflected on how this is

perceived to be out of the cultural tradition for her generation and from her perception can also create structural problems for rearing a child:

“...I guess, and also you know just growing up as an adopted person and you know your mother was not married. That was a terrible thing. So I certainly am keenly aware of the outcomes that the pregnant and we were really not talking about sex here, well indirectly, but pregnancies outside of a structure where the child can be taken care of creates all kinds of problems, for the individual, as well as for the group, and the society, and family...”

Rachel discussed that her connection to counseling psychology supports her interest in considering all intersectional identities of herself and clients to explore how these can be influential in navigating the relationship. She discussed how it's important for psychologists to do their own work and understand what has shaped their values about sexual health. She feels that engaging in self-reflective processes helps the psychologist create a safe space for the client and become more aware of their personal reactions to clients' experiences. Her values as a feminist and social justice advocate are two of the identities that have influenced her relationship with sexual health. She reflected on how these identities encourage her to be accepting of varying sexual experiences and to create a safe space for others to discuss their experiences. Her values as a feminist and scholar have also influenced her to seek knowledge through consulting with other professionals, attending training opportunities, and seeking relevant reading material:

“I mean broadly like if a therapist is, is more likes like sex negative is like towards that then I think it'd be really hard for a client to get their needs met. Right. It's similar to a racial identity stuff right. Like we want to have done more work so that we're not in regressive relationships with our clients. I think it's important for therapists to not be less open than their clients. And so again the importance of us doing our own work to figure that out. Not that we have like our behaviors don't have to be more open than our clients but just like an understanding of why we choose what we choose and what, what we're comfortable with. Again, to not have or show those like surprised or shocked or shame reaction I think is important. And then yeah. And to be able to create space to, to share that to, to be able to make it be this extra safe place because it is taboo to talk about this. And so like our ability to just have this feel like as, as normal as if we're talking about like time management like that's my goal is to have it be like yeah we're going to then and sometimes I will have sessions where we're talking about like talking about orgasm,

we're talking about time management, we're talking about like this like anxious that I have about my mom dying of cancer. Right. And that's all gonna be in there and we'll kind of move through all of those in the same sort of sense of the importance..."

Rachel spoke in length about how her upbringing in an evangelical tradition has been influential in her exploration of sexual health. She identified the environment as being "anti-sex" and "repressive" towards sexual health. She discussed how engagement in self-reflective processes has helped her to figure out what her background has instilled in her and values that she wants to keep or give away from the tradition. Rachel also discussed how her upbringing has resulted in her being curious about messages her clients might have received about sexual health growing up. Below she reflected on the process she engages in when considering her reactions and feelings to sexual health topics and their relationship to her values:

"...I also came from a very repressive background, like super evangelical like very much purity culture, all of those things. So, for me like a big part of my journey has been figuring out like what that upbringing instilled in me what I want to keep from it and what I want to give away...My background in, in coming from this really repressive background. And this very anti-sex sort of thing has helped me really think like okay, what, how did that happen? What did I internalize? What my client, my clients be internalizing? What like, what sort of messages might they have picked up from the culture without noticing it, and how do they kind of unpack that and figure out what they want it to be from there?"

Rebecca identified herself as a military psychologist that values and conceptualizes her clients from a multicultural framework. She reflected on how she uses this framework to maintain a respectful nature with clients regardless of their cultural background. She also discussed how she is motivated to assist veterans and expressed the need for the development of sexual health training that is specific to veteran needs. Rebecca focused primarily on characteristics of her personality that she values and that are useful in helping her explore client sexual health needs. Specifically, she identified herself as "not being shy or modest" and a direct

person with most topics. Below she discussed how she identifies herself as someone that is open to confront topics and barriers that might result if her personality style was different:

“...I'm sure there are people that are just themselves kind of you know don't like to rock the boat. You know I'm not really that way, but a lot of people are, and they certainly would I imagine that would be really hard for somebody who's not used to being that direct, I guess.”

Sonia identified as an Asian Indian woman and reflected on how those identities influenced messages that she received about sexual health growing up. Specifically, she reflected on how sex was a “taboo” topic that was not spoken about in her home. She discussed how she did not have a role model growing up to teach her how to engage in sexual health conversations. Through this reflection, she also acknowledged how her upbringing has influenced her role as a mother, but also how she engages in conversations with her pediatric clients. With her cultural background in mind, she uses this to consider the cultural family dynamics that might be influential in the lives of her pediatric clients. Therefore, she is very focused on having the parent’s present in the course of their children’s treatment to explore where children are receiving messages about sexual health:

“So, I think you know I think in general if I open up a conversation very openly, so I'd like, just to talk about an example of a referral I just got. This is not the same person I talked about, but they're coming in because the patient is like a 10-year-old kid and he is having intrusive images and thoughts about sexual things. And so, you know it's complicated because he's 10 and so one thing that I really made sure to do is really understand the family culture around these conversations. So, what conversations do families have around this? Where are kids getting it? Where are the kids that I'm working with getting knowledge about, you know, anything related to sexual health? Are they getting it from school or are they getting it from friends or are they getting from online, parents, extended family members? But also, really understanding the kind of family's perspective and view of sexual health and discussions of sexual health. And I know when I grew up, we didn't talk about like we just didn't talk about it. You know as an as an Asian Indian I grew up and my parents we don't talk about sex we didn't talk by any of those kinds of things. And so, it felt kind of like this taboo thing that like I know I need to talk about but I'm also like how I talk about it, I've never actually like had anyone role model this for me in my personal life. And so, I think you know I incorporate family

systems in that conversation because I think it is important to understand where families fall in that because kids are going home with their parents.”

Sonia also reflected on the role her identity as a primary care psychologist has on her ability and comfort in discussing client sexual health needs. She reported that her professional development in the primary care setting has assisted her in feeling more comfortable and willing to initiate sexual health conversations due to having opportunities to observe conversations being modeled by other professionals. Overall, she reflected on the relevancy of recognizing her own biases and cultural influences of sexual health could influence conversations with clients if they are not recognized:

“I think they, they might they might influence them by not feeling comfortable talking about it or overly talking about it because maybe they're very open about sexual health with and maybe bringing it up too soon and not really meeting the patient where they're at. So, I think you know I think my background in terms of my personal background I really reflect on you know when I'm when I'm choosing to do anything. If anything comes out of my mouth, why am I doing it. Is it for personal gain or is it for professional gain in terms of benefiting the patient, right? And so, I think we should all be thinking about when we bring up conversations about sexual health. How, how do our previous experiences with other patients impact this, how do their previous experiences with other people impact this? But also, what is the, what is the actual benefit right now for having this conversation? So, I think it's got to be. And also, I think my, my experience and training in primary care has really influenced my level of comfort but my willingness to talk about it. So, I think just the specific training that I've gotten in this in this field in this setting has really influenced my level of comfort...recognizing that we all come with our own biases and kind of culture, cultural frameworks to sexual health and what that means it and what it looks like. And so, what we bring to it I think is important but also what our history and our own experiences of sexual health and conversations about it also are important to understand and recognize.”

Structural Overview

This section of the findings provides a summary of common responses and experiences described by all of the participants. In particular, the structural overview will provide the reader with an understanding about how the participants as a whole described their experiences as counseling psychologists addressing sexual health needs of clients. This section will also

provide a summary of responses and experiences that were unique to the various interviews. Individual experiences of the phenomenon will be discussed based on unique experiences described by the research participants. The section will exhibit general essential features of the phenomenon within its structure. The information discussed will shed light into the variation that can exist in the participants' experiences with the phenomenon. A reflection of the participants' experiences will be connected to the research questions in order to describe their connection to the phenomenon of interest.

Superordinate Themes

Below is a list of the superordinate themes that reflect the participants' experiences with the phenomenon and emerged from the data analysis. The themes will be further described as they connect to the guiding questions:

- 1) Ability increased
- 2) Connection of counseling psychology values to sexual health
- 3) Sexual health competency
- 4) Sex-positive framework defined
- 5) Comfort increased
- 6) Sexual health conversations
- 7) Absence of training and supervision
- 8) Absence of continuing education
- 9) Educational suggestions
- 10) Relevance of personal identities and values

Guiding Question #1: How do counseling psychologists feel about their competency in sexual health to assist clients?

As a collective, the participants reflected on their ability to assist clients in addressing sexual health and overall identified feeling “okay” or “fine”. However, as the interviews progressed there was a sense, they felt less confident in their ability to assist sexual health issues of clients than they originally claimed. Their reflection on sexual health conversations with clients and difficulties they experienced in navigating these conversations started to become visible as they unpacked their direct experiences with the phenomenon. As a result, the participants appeared to question their ability in addressing sexual health needs of clients. Many of them attributed their perceived ability to their general professional development that occurred naturally as they progressed within their careers. All of them acknowledged a general unease of their ability that existed at the onset of their careers, which was attributed to their lack of training in graduate school. A general feeling of unpreparedness and incompetence in their ability to adequately address sexual health topics was felt amongst the participant responses. Most of the participants reiterated their lack of training throughout the interview and its impact on their ability to assist clients with their sexual health. The participants identified ways that support could have been present for them during graduate training by providing opportunities for modeling of skills and a space to engage in dialogue about their experiences in discussing the topic with clients. They also attributed their feelings of uncertainty in their ability to the social implications and taboo nature of the topic. There was a sense that participants felt issues could arise from them initiating the conversation due to social norms about discussing sexual health, and uncertainty about their ability to adequately navigate those situations.

Although all of the participants acknowledged an awareness of increased ability to address to sexual health issues with clients over time, the primary processes that aided them differed amongst some of the participants. For example, Michelle and Rebecca reflected on how

their ability has increased based on her habituation of the topic continues to occur. They feel more confident as they continue to actively engage in these conversations with clients and feels this will continue to increase throughout their careers. Both of them recognized that there are areas they continue to feel their ability is lacking and would benefit from additional training or support in strengthening. Donna reflected on how her professional experiences related to generational issues that were present throughout her career prompted her increase in ability to address sexual health issues with clients. She felt prompted to engage in these conversations with clients due to advocacy movements surrounding rape education and the AIDS crisis influencing the experienced of her clients. She reflected on feeling “fortunate” to enter into the field during a time when sexual health conversations were at the forefront of the field.

Rachel directly related her increased ability to a change in her geographical location and resources that were associated with both of those locations. In reflecting on her graduate training, she felt stuck in her training due to lack of resources and focus on the topic of sexual health. These absences resulted in her questioning her ability to adequately assist clients with their sexual health. She discussed the experience of relocating to the west coast and receiving an abundance of training opportunities and support to engage in sexual health dialogues with other professionals. As a result of these opportunities, she recognized a shift in her skill set and conceptualization of sexual health discussions with her clients. She found herself seeking more self-education opportunities and a sense of confidence in her ability seemed to rise as she emerged herself in these opportunities. Sonia identified that her professional development in an integrated primary care setting as responsible for her increased ability. She discussed feeling unprepared during graduate training practicum experiences due to lack of training opportunities or dialogue within the program. However, she feels more confident in her ability as she was

provided with modeling opportunities throughout her professional career in the primary care setting. She openly expressed her appreciation for the setting dependent skills she has gained, with sexual health being one of those skills. All of experiences from participants suggest that factors for increasing perceived ability in addressing sexual health needs of clients can be dependent upon the individual clinician and their relation to the phenomenon. These examples suggest that individual needs are important in consider when assessing an individual's experience with a phenomenon.

Guiding Question #2: What role do counseling psychology values play in the experiences of counseling psychologists in assisting their clients with sexual health?

All of the participants reflected on their strong connection to counseling psychology values and identified specific values that define their practice. Most of the participants reflected on ways they “found” counseling psychology and experienced its value as fitting to their personal values. Michelle, Donna, and Rachel reflected on how they connected with counseling psychology because the values fit naturally with feminist values, and identity of great importance to them, that had been established prior to selecting psychology as a profession. They recognized the moment of finding a profession that aligned with their values as a milestone in their personal and career development. The values that define counseling psychology naturally fit with the lens they use to develop their worldview and to conceptualize the needs of their clients. All of the participants felt that counseling psychology values a contextual, systemic approach that aims to consider the holistic person and influences from various forces within their context that shape their experience. The field also promotes active involvement in social advocacy on various levels and a curiosity for social justice issues. The primary force that drove the participants to the field is its multicultural focus that further helps to contextualize the

experience and stories of the clients. The participants reflected on how these values are congruent with their personal values and applicable to the various settings they have practiced.

The participants all agreed that counseling psychology values are beneficial in helping them conceptualize and frame sexual health conversations with clients. However, some of the participants spoke directly to specific values that help them navigate these types of conversations with clients. Michelle, Donna, and Sonia reflected on how these conversations have a macro or systemic effect on entire groups of people, especially those whom have been historically marginalized. They discussed their interest in assessing the interaction of systems that might be influential to a person's sexual health experiences. Therefore, they can use the knowledge and awareness to "rise up a level" and enact changes for marginalized groups of people on an individual and systemic level. The participants identified how this aligns with their counseling psychology values of multiculturalism, social advocacy, and conceptualization from a systemic frame of reference.

Rebecca spoke directly to the importance of viewing clients from a health perspective that could be improved upon for their overall wellbeing. Further, this could be supported by acknowledging their strengths and building upon them to provide Rachel spoke to how she uses the holistic nature of counseling psychology to assess the various identities that are interacting to inform their sexual health experiences. Similar to the previous participant, she uses the information about the person's intersectionality of identities to assist them from a wellness model that aspires to provide them with optimal connection to their sexual health.

All of these examples highlight the meaning the participant's place on their counseling psychology values in helping them navigate sexual health conversations with clients. Self-reflection of their personal values and their alignment with their professional values cooccur

during their experiences with assisting clients with this topic. The participants highlighted numerous values that drew them to the field of counseling psychology and that balanced with their personal values. All of the participants acknowledged their passion for counseling psychology and highlighted the role its values play in helping them navigate difficult dialogues with clients, especially those related to sexual health. Although some of the participants reflected on specific values that help them navigate these conversations, overall, they expressed a sense of pride about the values that help them shape their profession and support clients' complex needs.

Guiding Question #3: What meaning do counseling psychologists apply to a sex-positive framework?

All of the participants acknowledge engaging in sexual health conversations with clients throughout their professional career and felt “pretty comfortable” with having the conversations. The participants identified similar sexual health topics they discuss with clients such as consent, intimacy, boundaries, sexual functioning, sexual dysfunctions, transgender care, etc. Most of the participants disclosed their experiences of feeling discomfort with discussing sexual health issues during their graduate school clinical placements due to feelings of incompetency. They often felt uncertainty about how to broach the conversations and felt their training programs did not support them in developing this skill. However, as they progressed in their professional career, they identified an increase in the frequency and their comfort with discussing sexual health due to habituation. Some of the participants acknowledged that they continue to feel discomfort in discussing certain sexual health topics with clients such as masturbation or current sexual functioning due to the sensitive, taboo nature of the topic.

Some of the participants discussed feeling more comfortable with these conversations and therefore engaging in them more frequently than other participants. Also, those who had a professional interest in sexual health identified initiating the conversation with clients more easily and more frequently than participants that did not identify sexual health as a general professional interest. Rachel and Donna identified other influences that have assisted them in naturally engaging in these conversations with clients; relocation to a geographical location that is accepting and supportive of sexual health issues and the beginning of a career during an era that was more socially supportive that generated systemic conversations about sexual health. Rebecca and Sonia discussed how they primarily initiate sexual health conversations because they are connected to a standardized process that is setting dependent. They reported feeling discomfort and infrequent attempts to discuss sexual health with clients outside of this context. Specifically, they denied inquiring about general sexual health functioning and wellbeing due to feeling uncomfortable with initiating this conversation in their particular professional settings. Although all of the participants acknowledged engaging in sexual health conversations with clients, all of the identified topics or situations that continue to result in feelings of discomfort. They attributed this discomfort to the taboo nature of the topic, but also to their lack of sexual health training in graduate school and educational training opportunities.

All of the participants identified that training programs can approach sexual health competency similar to other areas of competency. Specifically, all of them identified they could focus on building trainees' knowledge, awareness, and skills in sexual health. Also, most of the participants agreed that special consideration be taken for values such as openness, multiculturalism, and social contextual factions. Michelle and Rachel identified sexual health competency as ongoing and an orientation to a specific way of knowing. They discussed how

this could be viewed as a spectrum that is ongoing without an end. All of the participants reflected on how graduate training would be the most appropriate place to achieve this competency. However, they all acknowledged feelings of incompetency due to feeling unsupported by their graduate programs in developing their sexual health competency. Many of them reflected on alternative ways they obtained sexual health competency such as through self-education from relevant reading material, seeking consultation from knowledgeable colleagues, engaging in dialogues with supportive colleagues, and obtaining opportunities for modeling from other professionals that engage in sexual health conversations with clients. All of the participants expressed how they would feel more comfortable and willing to initiate sexual health conversations with clients if their competency was increased within this area. Specifically, many of the participants felt additional general knowledge of sexual health and examples of ways to initiate conversations would be helpful to increasing their competency. They also felt that gaining additional competency would help them better conceptualize and guide sexual health conversations with their clients.

Most of the participants initially struggled to define a sex-positive framework for sexual health. They required a brief definition and introductory foundation of the topic to conceptualize how they understand sex-positive in relation to their work in assisting clients with their sexual health. Donna attributed her ignorance of the term to her age and reported her experience with being trained in “sex negative” during her graduate training. She reflected on her experience of how she was informed about ways that sex can be harmful to others. From this framework, she reflected on her assumption of how sex-positive is most likely the opposite and encourages sexual health to be positively expressed. She discussed her insight during the interview that she had been practicing with this assumption in the later part of her career. Michelle and Rachel

were familiar with the term and discussed how their experience with the term derived from their feminist roots. However, they reflected on how their feminist values transformed throughout their careers as the progression of the waves of feminism ensued. Regardless of how the participants experienced the term, all of them identified similar values to define sex-positive and how the process relates to their values as a counseling psychologist.

All of the participants reflected on their understanding that a sex-positive framework encouraged openness and approaches a client from a non-judgmental stance. They reflected on experiences with assisting particular clients with their sexual health in which they used these values to build rapport with a client and navigate the conversation. Most of the participants defined this framework as one that considers the holistic person, especially their cultural identities when addressing sexual needs of clients. Michelle and Rachel, whose understanding of sex-positive was rooted in their feminist identities, defined this framework as one that is “affirming about sex” and seeks to help the client obtain optimal flourishing and pleasure with their sexual health. They reflected on their experiences with clients and how this framework reminds them that sexual health is relevant to the lives of all clients. The participants reflected on how they naturally engage in these conversations with clients since the values are tied to various aspects of their identities as a feminist and counseling psychologist. Although some of the participants did not initially connect its relevance directly to their values as a counseling psychologist, when prompted they discussed how their counseling psychology values and mission naturally guides them to engage in sexual health conversations in a similar manner.

Guiding Question #4: What experiences have counseling psychologists had with sexual health training within their graduate programs and outside of their programs?

All of the participants reflected on the absence of foundational sexual health training in the graduate programs. Sonia acknowledged feeling “sad” at the end of the interview due to her insight into insufficient graduate training. Other participants reflected on similar feelings of recognizing the importance of sexual health training in graduate school as they completed the interview. The participants all discussed how their lack of training has directly influenced their feelings of competency and comfort in addressing sexual health needs of clients. Some of them reported feeling like they “didn’t know” how to navigate some sexual health conversations due to an absence of modeling and dialogues about the topic in their programs. They all acknowledged an absence of courses or dialogue about sexual health in related courses. Many of the participants reported uncertainty about its relevancy in their coursework until the topic became relevant with their clients in clinical placements. A few of the participants reported engaging in sexual health related conversations with clients during practicum and internship experiences. They reported feeling uncertain about how to navigate the conversations and at times felt uncomfortable. It was during these times they realized sexual health was a competency absent from their graduate training.

Donna remembered her experience with sexual health training during the era of the AIDS crisis and onset of rape education in university counseling centers. She discussed how the social lens shaped the “sex negative” dialogue and educated her about ways that sex can be harmful. However, she still acknowledged that she did not receive any training or engage in dialogues during her academic courses. Rachel recognized that she obtained sexual health training when she relocated to the west coast and the topic was more openly discussed. She reflected on how she was in her internship and received continuing education various topics such as sexual aversion, polyamory, and sexual subpopulations. Similar to the other participants, she denied

any sexual health dialogues while she completed courses in her graduate program on the east coast. Therefore, these two participants attributed their sexual health training to their clinical placements and acknowledged their training would have been limited otherwise.

The absence of competent supervisors was unprompted and acknowledged by three participants. Michelle, Rachel, and Sonia reflected on feeling unsupported by their supervisors in navigating sexual health issues with clients. They all felt their supervisors lacked sexual health competency and were unable to adequately assist them in building their own competency in this domain. Michelle reflected on her interest in wanting to have more frank conversations with her supervisor but experiencing feelings of discomfort due to the dynamics occurring with her male clients and her supervisor identifying as male. She discussed how she would have benefited from a competent supervisor that inquired about these conversations and modeled them during supervision. Rachel and Sonia reflected on how they gained the skills to navigate sexual health conversations with the assistance of other colleagues and referenced this was due to lack of training in their graduate program and support from supervision. Therefore, supportive and competent supervisors would further benefit trainee's growth of sexual health competency.

The participants acknowledged an absence of continued training opportunities relevant to sexual health. Michelle and Rebecca discussed their participation in trainings related to transgender care, but otherwise identified a lack of opportunities in expanding their professional competency in this domain. The participants reflected on alternative ways they have attempted to independently increase their competency by seeking relevant reading material and consulting with knowledgeable colleagues. Rachel and Sonia discussed how this reflects a larger systemic issue within the field of psychology and warrants a push for more support from professional organizations. They suggested professional organizations incorporate sexual health topics into

their trainings, create special interest groups, or host relevant webinars. The participants' reflections suggest that professional educational opportunities for post-graduate training are needed within the field.

The participants identified educational opportunities that would be beneficial in supporting graduate trainee's sexual health competency during graduate training. All of the participants reflected on opportunities that would build upon a trainee's knowledge, awareness, and skills through various facets. They specifically reflected on their experiences during graduate training and identified opportunities they felt would have been beneficial in supporting their sexual health competency. Many of the participants discussed the benefit of incorporating sexual health into didactic training and clinical practice. For example, all of the participants identified benefits of gaining knowledge on relevant sexual health research. Additionally, this would provide the opportunity to create a dialogue amongst professionals. They discussed how this could build the foundation for the practice of skills at clinical placements.

All of the participants reflected on how they would have benefited from modeling of how to initiate and navigate sexual health conversations with clients. Specifically, participants identified the utility of modeling from a primary supervisor during practicum or internship placements. Most of the participants also suggested the use of role playing during clinical skills classes. Lastly, most of the participants identified the need to encourage self-reflective practices from trainees in order to explore their own biases and values about sexual health. The participants discussed how some of their programs encouraged self-exploration and educated them on how to engage in difficult dialogues that challenge their value expression. All of the participants discussed how incorporating these educational opportunities would benefit trainee competency and their level of comfort in addressing sexual health needs of clients. Reflecting

back, all of the participants attributed their competency and level of comfort to the training they received in their graduate training program and through educational opportunities outside of their programs.

Guiding Question #5: What role does the counseling psychologists' personal values play in assisting clients with their sexual health?

The participants' acknowledged the importance of recognizing their personal narratives and values when addressing sexual health needs of clients. All of the participants agreed their experiences with their various identities can directly influence sexual health conversations with clients if they are not engaging in ongoing self-explorative process. They all agreed the benefit of engaging in this process is to continue to remain objective and create a safe space for clients to openly engage in conversations about their sexual health. The participants reflected on various identities related to their gender, religion, parent status, sexual orientation, and feminist connect that might be influential in how they, and clients, navigate sexual health conversations. Rachel and Sonia reflected on being raised in repressive backgrounds that refused to acknowledge or engage in conversations about sex. Both of the participants discussed how these experiences shaped their initial discomfort and ability to engage in conversations with clients early in their careers. Sonia specifically discussed her experience of recognizing the absence of a role model in her household and graduate training to model productive sexual health conversations. Rachel discussed how she used this self-reflection to identify internalized messages she received growing up and challenged those she felt were unproductive.

Donna spoke in length about the effect of her identity as an adopted person. During the interview she identified a value that sex outside of relationships is not as healthy as within a relationship. She expressed insight into this value through the interview process and identified

this as a bias of hers that is connected to her adopted identity. She reflected on knowledge about her being born out of wedlock and the stigma that was placed on her mother as a result. She also reflected on a shift in her values about gay sexuality that occurred after a close family disclosed his sexuality. Rebecca and Sonia reflected on their professional identities from specific settings, such as pediatric primary care and the military, and how they have shaped their values about sexual health.

These two participants related with one another in how they connected to the values of their particular professional setting. Rebecca, who is connected to her military identity, discussed how the culture of the setting has influenced her level of comfort with certain topics that are normalized within the military. Specifically, she reflected on her experiences inquiring about pornography use with veterans and her level of comfort with this topic due to acceptance within the general military culture. Sonia, who practices in pediatric primary care discussed how this identity has shaped her understanding and approach of sexual health conversations with clients. For example, she discussed how the setting normalizes sexual health conversations and required her to consider how her values, even as a mother, might influence her perspective when assisting families with sexual health concerns. All of the participants reflected on experiences with engaging in self-reflective processes and analyzing their influence on the lens they use to conceptualize sexual health needs of clients.

Inter-Codal Agreement

The inter-codal agreement was completed by the principal investigator and research auditor to check for consistency in the selection of the themes (Appendix G). The principal investigator initially identified a list of 15 superordinate themes from the data after reviewing all of the transcripts and completing a code book with consideration to the guiding questions. The

research auditor was provided with the 15 themes and a selection of quotes from the participant's transcripts. The research auditor was asked to match the appropriate theme to the quote or identify a new theme with a definition. The research auditor was provided space to memo about questions or concerns the principal investigator might need to consider. They both completed the form separately and discussed differences amongst their themes to reach a resolution.

Overall, there was a general agreement amongst the theme selection between the principal investigator and research auditor. The research auditor identified confusion and repetition of five themes that were eventually removed or combined with other themes before identifying the final list of superordinate themes. The three themes removed during this process were presence of discomfort; feelings of incompetence; and social influence. These themes were removed since they were able to be reviewed in the discussion of more appropriate themes that better explained the participants' experiences with the phenomenon. The themes of continuing education and counseling psychology values were combined with other themes, as they were able to be appropriately addressed in conjunction with other themes. Further, the research auditor initially identified more than one theme that fit with the provided quotes, but eventually narrowed their selection to one theme that fit most appropriately with each quote. This occurred in collaboration with the principal investigator and discussion to reach an agreed consensus of a final list of superordinate themes. The research auditor attributed their initial list of themes to a lack of context from the quotes but was provided with additional context upon collaboration from the principal investigator.

Summary

The findings presented in this chapter were compiled from individual interviews and critical incident questionnaires. The information was used to encourage and facilitate critical

reflection to capture the true essence of counseling psychologists' experiences in addressing sexual health needs of clients. Each participant shared their personal experiences addressing sexual health needs with clients and identified barriers and strengths that have assisted them with the process. Although each experience is unique, similarities existed that connected their stories together to identify 10 superordinate themes. The superordinate themes and nuances specific to each participant were reviewed. Further, a structural overview of similar and differing themes that existed amongst the transcripts were reviewed. The final phenomenological description will be discussed in chapter five, along with study implications, outcomes, and recommendations.

CHAPTER V: DISCUSSION OF FINDINGS AND ANALYSIS

Overview

This chapter will discuss the implications of the study findings and draw a connection to the existing literature about counseling psychologists' experiences addressing sexual health of clients from a sex-positive perspective. Interpretations of the data will be made, and conclusions will be drawn about clinical practice and relevance to the field of counseling psychology. Limitations of the study will be outlined and recommendations pertaining to counseling psychology practice, training, and future research will be presented.

Phenomenological Analysis of Experience

This study has attempted to provide greater understanding of counseling psychologists' experiences in addressing sexual health of clients. Accordingly, this section elaborates on the conclusions and interpretations about the superordinate themes that emerged from the participants' experiences. The experiences of the participants yielded answers to all of the guiding research questions. The most significant findings revealed ten major themes that encompassed the essence of the participants' experiences.

Ability increased

The counseling psychologists' ability to assist clients with their sexual health was of significant concern for the participants in the study. In reflecting on their experiences with their perceived ability, the participants revealed concerns about its development. Although most of the participants acknowledged their ability increased over time, they revealed continued concerns about whether this was aligned with expected professional competency of this phenomenon. The participants reflected on how increased exposure has primarily attributed to their increased

ability. Additionally, others attributed this to their career in a specific geographical location, professional career setting, and the social lens' influence on recognition of sexual health topics. Although the participants felt their ability has increased, there was a sense of frustration with how this occurred. For example, most of the participants acknowledged their ability should have been supported by their graduate training programs. Most interestingly, this recognition of the participants' experiences was typically unsolicited during by the principal investigator during the interview. This theme highlights different ways a professional's ability can be increased and the relevance of graduate training programs supporting sexual health competency during graduate training.

Connection of counseling psychology values to sexual health

The participants identified values specific to counseling psychology that motivate their practice. All of the participants had a strong connection to counseling psychology and reflected on their experience with choosing to pursue this area of psychology. There was a sense of pride from the participants that they chose to pursue a career in counseling psychology. All of the participants identified their counseling psychology values as relevant to how they approach sexual health needs of clients. They felt the holistic, culturally focused values of counseling psychology were especially relevant to how they approach sexual health conversations with clients. Additionally, all of the participants felt the values were congruent with their personal values and lens they use to navigate the world. This theme suggests the integration of counseling psychology values as viable to framing sexual health conversations.

Sexual health competency

Some of the participants initially struggled to define sexual health competency. They felt uncertain since they felt this had not been addressed in their graduate training. Over the course

of interview, all of the participants defined sexual health competency as having adequate knowledge, awareness, and skills. They defined this process as ongoing throughout the course of their careers. All of the participants had a realization by the end of the interview that they did not gain sexual health competency through the support of their graduate training program. Instead, they identified ways they have obtained some competency through consultation with competent colleagues, reading relevant material, and seeking professional trainings. However, all of the participants continued to discuss uncertainty about their level of competency pertaining to their skills. The reality for most of the participants was that they felt uncertain and uncomfortable about their ability to inquire about sexual health or general sexual functioning.

Sex-positive framework defined

Some of the participants were initially unfamiliar with the sex-positive framework. Those unfamiliar with the term were provided with a brief definition in which they all realized a connection to the framework related to their counseling psychology identity. Some of the participants reflected on practicing from this framework due to its connection to their feminist identities. Overall, the participants identified similar values that were foundational to a sex-positive framework such as multiculturalism, social justice, nonjudgmental, and openness. The participants also connected the similarity of these values to their personal and professional identity as a counseling psychologist. All of the participants identified feeling connected to this framework and recognized its importance in shaping how future counseling psychologists are trained in sexual health.

Comfort increased

All of the participants recognized an increase in their comfort over time. There was not a specific amount of time mentioned by the participants, rather a recognition of their personal

experience with feeling more settled in sexual health conversations with clients. The participants also attributed this change to other contributing factors such as presence of a larger social conversation, relocating to the west coast, and a supportive setting that provided opportunities for modeling. Overall, the participants recognized an increase in their comfort as a result of their increased exposure to the topic by another source. All of the participants reflected on the role their comfort plays in initiating and navigating sexual health conversations with clients.

Sexual health conversations

All of the participants acknowledged engaging in sexual health conversations with clients at some point in their career. Some felt they engaged in the conversations more frequently than others, and this often correlated with their level of comfort or perception of their ability to discuss sexual health. A few participants discussed their experience with openly inquiring about sexual health functioning and wellbeing, as they had already been practicing from a sex-positive framework. On the other hand, a couple of the other participants discussed their experiences of inquiring about client sexual health primarily when prompted by a standardized intake or assessment for their clinic. They expressed discomfort with inquiring about a client's current sexual health satisfaction and/or functioning due to concerns causing discomfort for the client. Overall, the participants revealed they all engage in sexual health conversations and the range of topics are broad.

Absence of training and supervision

All of the participants recognized an absence of sexual health training in their graduate training. They identified there was an absence of courses and dialogues about sexual health topics during their graduate training. During this interview, the participants discussed their realization of this and some reported feeling "sad" about this fact. They all recognized this as an

area that should be incorporated into graduate training. The participants also attributed their feelings of discomfort and absence of skills to this gap in their training. A couple of the participants recognized an absence of conversations and discomfort initiating conversations with their supervisors in clinical placements about their clients' sexual health issues. One of the participants recognized the dynamics of her identities and her male supervisor's identities as influential in her avoidance to discuss this topic in supervision.

Absence of continuing education

Most of the participants recognized an absence of continuing education opportunities available. They discussed how these opportunities would be beneficial since their competency was not supported in their graduate training. One of the participants discussed her experience with having an abundance of continuing education opportunities upon her relocation to the west coast. She reflected on how these opportunities have assisted in building her competency and filling in gaps that were the result of minimal sexual health training in graduate school. The participants discussed feelings of disappointment in the profession and its governing bodies for not adequately supporting them in building this competency.

Educational suggestions

All of the participants identified educational suggestions they would have benefited from in graduate training. All of them reflected on how they would have benefited from open dialogues about sexual health within the classroom environment. The participants also wished there would have been an encouragement for them to engage in self-reflection about their values about sexual health and its implications for their practice. Given this is a sensitive, taboo topic, the participants suggested future training incorporate self-reflection specific to sexual health in their programs. Most of the participants discussed feeling unsure about how to appropriately

inquire about sexual health. They all acknowledged that training programs should consider incorporating role play or modeling opportunities to learn this skill.

Relevance of personal identities and values

A person's identities and values were recognized to be important in navigating sexual health with clients. Many of the participants recognized how their personal journey with sexual health was relevant for them to reflect upon. They identified other identities related to their gender, race, ethnicity, religion, and parenthood as influential in their perceptions and understanding of sexual health. A few of the participants reflected on the role their feminist identity played in directing them to their current profession and how they conceptualize client sexual health needs. Some of the participants discussed their awareness of specific biases and how they avoid allowing them to disrupt sexual health conversations with clients.

Results Compared to the Literature

Sparse qualitative research exists on exploring psychologists' experiences in addressing sexual health needs of clients. Currently the literature points to few articles that quantitatively explored the experiences of clinical psychologists in assisting clients with their sexual health needs. The literature revealed that clinical psychologists' training experiences were suggested to be influential in their ability and comfort in addressing sexual health needs of clients. They further highlighted that an absence of professional support in developing competency influenced their likelihood to initiate sexual health conversations with clients (Miller & Byers, 2008; Miller & Byers, 2009; Reissing & Giulio, 2010). The findings of these studies highlight the basic assumption that psychologists, broadly speaking, benefit practically in their efforts to assist clients with sexual health needs when supported by their training programs.

Although similarities are expected to exist, there is even less known about the experiences specific to counseling psychologists. Counseling psychologists proudly acknowledge specific values that connect them to their practices as a counseling psychologist. For example, the literature highlights that counseling psychologists minimally are sensitive to the needs of diverse populations, use self-reflective practices to guide their dialogues, and approach issues from a social-justice lens (Ivey & Collins, 2003; Linley, 2006; Lopez et al., 2006). Given these key identifiers of counseling psychologists, one would assume that the area of sexual health has been explored through this framework. However, as an area of research, this phenomenon has minimally been comprehensively examined or considered by researchers in the field of counseling psychology. A close review of the counseling psychology literature reveals that few scholars have documented and pursued sexual health research from an exploratory, qualitative approach. Most recently, counseling psychology literature released a major contributory proposal for the need to progress this research for the benefit of future psychologists and clients. This review suggested that sexual health has been studied primarily from a narrow viewpoint that has underrepresented the breadth of sexual health topics and their relation to diversity (Hargons, Mosley, & Steven-Watkins, 2017). An absence of research about licensed counseling psychologists' experiences in assisting clients with their sexual health was noted. This highlights the necessity to utilize the experiences and values of counseling psychologists to navigate the training and development of future sexual health literature.

The results of this research support prior findings about the utility of approaching sexual health competency through the building of basic competency foundations. Specifically, the literature has suggested that adequate knowledge, awareness, and skills of a phenomenon constitutes competency in the field of psychology (Donovan & Ponce, 2009; Fouad et al., 2009;

Hatcher et al., 2013). Similarly, the participants in this study identified sexual health competency as relevant to their current knowledge, awareness, and skills of sexual health. All of the participants felt that trainees should be provided with adequate knowledge on various sexual health topics and techniques; be encouraged to engage in self-reflective processes about their sexual health values and biases; engage in active dialogues about their reflective processes with peers or other professionals; and able to use skills to navigate sexual health conversations with clients. A couple of the participants viewed sexual health competency as a spectrum and identified it as an “orientation” to sexual health that is ongoing. This highlights the consistency of defining general competency that exists amongst counseling psychology professionals.

Most of the participants acknowledged an absence of sexual health competency and attributed this to their lack of opportunities in their graduate training or clinical placements. Previous research specific to counseling psychologists suggested that most graduate programs did not offer a course specific to sexual health, nor did they incorporate adequate training into relevant courses (Burnes, Singh, & Witherspoon, 2017). Similarly, the results of this study suggested a general absence of sexual health training or dialogue within their graduate training programs. Most of the participants were unable to recall opportunities’ for acquiring knowledge or skills on how to navigate sexual health conversations. Additionally, they denied encouragement by their programs to engage self-reflectively about their biases and values related to sexual health. All of the participants identified these opportunities as relevant to their competency and level of comfort to address sexual health needs of clients, which was similar to previous research findings of clinical psychologists’ experiences (Miller & Byers, 2008; Miller & Byers, 2009; Reissing & Giulio, 2010). Some of the participants felt the lack of continuing education training has also influenced their absence of sexual health competency. Most of the

participants were unable to recall any counting education opportunities that would have extended their competency in sexual health. This is similar to previous research that suggested that psychologists were more likely to directly ask about and assist clients with their sexual health needs when receiving more educational opportunities (Miller & Byers, 2009). This study highlights the absence of graduate training and professional continuing education opportunities available to build upon trainees' sexual health competency.

Previous literature has suggested the medicalization of sexual health in the field of psychology. Similar to a medical model, the diagnostic model in psychology adopted a process of characterizing pathological and clinical findings, exploring a known course for the pathology, and providing specific responses to treatment (Galatzer-Levy & Galatzer-Levy, 2007; Pilecki, Clegg, & McKay, 2011; Zalaquett, Fuerth, Stein, Ivey, & Ivey, 2008). This model has been used to inform psychologists in assessing sexual health needs of clients. Some of the participants in this study acknowledged they often navigate sexual health conversations from a standardized nature that is focused on dysfunction and risk. Another participant reported being trained in a "sex negative" framework in which she often assesses ways that sex can be harmful to patients rather than focusing on sexual health through a positive lens. With this in mind, recent literature has suggested the utility of approaching sexual health through a sex-positive framework. This framework promotes sexual health as a normative process of human development that can vary for each individual and across contexts. The framework also emphasizes the exploration of an individual's pleasure and wellbeing in relation to their sexual health (Harden, 2014).

At first glance, similarities between the values of a sex-positive framework and counseling psychology values have been noted. However, the literature has also suggested an absence of sex-positive sexual health training occurring in graduate training programs (Hargons,

Mosley, & Steven-Watkins, 2017). Participants of the study connected with the sex-positive framework. Although some of them were unfamiliar with this approach, they felt connected to its values after being provided with a brief definition. Other participants reported using a sex-positive framework to guide sexual health dialogues with clients due to its open, nonjudgmental nature and its connection to their professional values. Similar to suggestions in the literature, the participants suggested a sex-positive model's reflection of the integration of multiculturalism and self-exploratory processes (Mosher, 2017). They felt this was reflective of their personal and professional values as a counseling psychologist that help guide their practices. Essentially, the values of a sex-positive framework and counseling psychology coincide to amplify the importance of a balanced, holistic approach to sexual health. This study highlights the connection of a sex-positive framework and counseling psychology values that future training might consider incorporating into their graduate programs.

Suggestions have been made in the literature about the utility of certain educational opportunities to increase sexual health competency of psychologists. The APA highlights ethical implications for an ongoing and genuine commitment to a reflective process, particularly in exploring sensitive, taboo topics (APA, 2012). The sex-positive literature also references the utility of critical self-reflection about one's internalized sexual health biases and values (Cru, Greenwald, & Sandil, 2017). Similarly, participants in this study identified self-reflection as an essential opportunity for trainees to build on their awareness competency. All of the participants found this essential to effectively navigating sexual health conversations with clients to avoid projection of their own values onto the client's experiences. The literature also highlights how developing sexual health knowledge can substantially lead to greater comfort and competency (Hanzlik & Gaubatz, 2015; Reissing & Giulio, 2010). Minimally, the sex-positive literature

suggests that psychologists be aware of sexual dysfunctions, desires, and relational patterns (Cru, Greenwald, & Sandil, 2017). The participants in this study also recognized the role limited sexual health knowledge has played in their ability to navigate sexual health conversations. Some of the participants reported being unfamiliar with basic sexual health concepts due to lack of support in their graduate training. This uncertainty required some of them to engage self-education about the topics, while one participant admitted to referring clients based on lack of knowledge. This highlights the need for consideration to incorporate sexual health self-exploratory processes and knowledge acquisition into graduate training programs.

The use of role-play and/or modeling has been suggested to be beneficial for professionals in building their sexual health competency. Previous literature has suggested that psychologists benefit from modeling of how to appropriately inquire about client's sexual health needs (Miller & Byers, 2008). Further, opportunities to role-play potential client scenarios about sexual health needs may be incorporated into current clinical skills courses. Participants in this study suggested these educational opportunities would have been beneficial in them building their sexual health competency during their graduate training. The participants identified role playing with peers or having observational opportunities of their supervisors or competent faculty engaging in sexual health conversations with clients would have supported their growth. One participant discussed how she received modeling opportunities of how to inquire about sexual health during her internship at an integrated primary care setting. She identified this as a memorable experience in building her competency and providing her with a framework on appropriate supervision tools she has since used in her current practice. This highlights the benefit of incorporating role-playing or modeling opportunities of sexual health conversations into graduate training programs.

Study Limitations

Several limitations were present in the study as a result of the methodologies used to explore the phenomenon. Given the nature of qualitative research, various factors can be influential to the methodological style, interview practices, and interpretations of participants' experiences. The researcher took care in considering possibilities that could occur throughout the steps of the research by considering the most effective way to obtain the information; being open to participant selection techniques; and utilizing a research auditor to check for consistency amongst themes. However, although some the limitations were considered at the outset, other unforeseen limitations emerged throughout the process. This study faced limitations primarily with the potential for bias with the methodological approach; response rate for participation; an absence of demographic variability; and participant willingness and availability to participate in an in-depth lengthy interview.

The nature of phenomenological research requires awareness of potential reliability and validity concerns. Biases are a natural human instinct that have the potential to arise when the researcher experiences feelings about a phenomenon. This is especially true when the topic at hand consists of a sensitive, taboo topic such as sexual health. Although I was encouraged to review my biases, beliefs, and values before initiating the study, the potential for biases to influence the data still exists. As the principal investigator, I am also tasked with the goal of convincing myself and the audience that the findings I presented are based off a critical investigation of the participants experience with the phenomenon. This suggests that phenomenological researchers be mindful to avoid interpretation of individual responses and instead identify their consistency or inconsistency with similar research. Perhaps future research

might replicate this study and identify the degree of variance that exists to establish a foundation for this phenomenon.

The response rate for participation was relatively low for this study. Initially the study sought to obtain 10-15 participants, but this was later amended after there were unforeseen difficulty obtaining participants. Minimal exclusionary criteria were used for participant selection in hopes to gain a rich, heterogenous sample of licensed counseling psychologists that have assisted their clients with sexual health needs. Even using sparse exclusionary criteria, gaining the minimal number of participants required significantly longer time than originally expected. Further, this difficulty required an addendum to be completed to expand the pool of counseling psychologists contacted. However, the study maintained a low response rate and participants were primarily selected from snowball sampling due to a general interest in the topic of sexual health and their relationship with other participants. Therefore, the results might not be representative of counseling psychologists' experiences as a whole due to participant favorability bias to the general topic of sexual health and relationships amongst the participants. Perhaps future research might extend the methodology of participant selection to reach licensed counseling psychologists within the field as a whole.

The low response rate limited the demographic variability within the study. All of the participants in the study identified as females and primarily identified as Caucasian. The study obtained one minority female that identified as Asian Indian and did not obtain interest from other minority persons. There was also an absence of gender diversity in participant response to participate in the study. Further, the participants primarily pursued their graduate training and practiced in coastal states, leaving an absence of data about training programs and general practice competency in other areas of the country. Although there was one participant outside of

the range, most of the participants had been practicing as licensed counseling psychologists between 5-8 years. With this in mind, more variability in the participant demographics might highlight contextual differences in how the phenomenon is experienced. Perhaps future research might broaden the participant sample by utilizing additional resources or more time to locate participants.

Implications of the Study

The development and analysis of the study revealed several implications about counseling psychologists' experiences in addressing sexual health needs of clients from a sex-positive framework. Through the use of a phenomenological approach, the principal investigator was able to capture the experiences of an area of research that previously lacked breadth. A phenomenological approach aided in the exploration of counseling psychologists' experiences in addressing sexual health needs of clients by using the participants' voices to explain the phenomenon. The essence of their experiences provided a richer understanding of unique perspectives with their experiences assisting clients with sexual health needs. Given the sensitive, taboo nature of this topic the research method gave participants the opportunity to explore their feelings with the phenomenon and its implications for their practice. Further, its emphasis on convergence and divergence of participant experiences gives the reader an overview of experiences that might exist for counseling psychologists with this particular phenomenon.

The results suggest recommendations for training, practice and research for the field of counseling psychology. Counseling psychologists reflected on their experiences with the phenomenon and the data of their practices revealed numerous ways the field might better support future trainees. Overall, the participants reflected on their experiences of feeling unsupported by their training programs and, and the field in general, in developing their sexual

health competency. The participants' dialogues highlight how their feelings of being unsupported has affected their ability to confidently assist clients with complex sexual health needs. Their suggestions for building a foundation in sexual health competency further highlights the complexity that is involved in building a trainee's knowledge, awareness, and skills in this domain. Perhaps future research may implement these recommendations and extend upon the limitations of the study to continue supporting counseling psychologists in providing best care practices for clients.

The participants in the study identified sexual health competency as similar to other competences taught in counseling psychology training. All of them acknowledged that competency foundation is based off one's knowledge, awareness, and skills of a particular phenomenon. However, this study highlighted the absence of these sexual health competency foundations within graduate training programs. The participants reflected on an absence of opportunities to acquire general knowledge or engage in dialogues about sexual health needs of clients. They also discussed an absence of encouragement for them to engage in self-reflective practices about sexual health and opportunities to process the implications of the outcome of their self-reflective process. The participants also did not feel these opportunities were present within supervision experiences or training opportunities outside of their training program. Given the sensitive, taboo nature of that topic that was recognized by the participants, they felt these absences were influential to their experiences in assisting sexual health needs of clients in clinical practice and research.

Further, participants felt these absences directly influenced their ability and comfort in assisting clients with their sexual health needs. They felt training programs and clinical placements are responsible for building and supporting these professional foundations. A

notable outlier in graduate training was made by one participant that identified increased support and opportunities upon her relocation to the west coast. She noted an overall increased acceptance and inclusion of sexual health in opportunities at her internship on the west coast, which was notably different from her, and other participants' experiences, with training on the east coast. Therefore, these findings suggest the need for consistent and increased sexual health training opportunities within graduate training programs and the field of counseling psychology as a whole. Specifically, graduate training programs would benefit future trainees by providing them with appropriate knowledge or access to resources about sexual health. The results also suggest that training programs would further benefit from providing trainees with opportunities and support to engage in open dialogues about their experiences with challenges and success in assisting clients with their sexual health needs. Given that this particular topic initiates natural feelings of discomfort or uncertainties for some, trainees would benefit from support to process these feelings. This study indicates the need for trainees and professionals to converse and learn from their peers about how others have navigated sexual health conversations with clients. This space would give trainees the support to reflectively examine their personal biases or values related to sexual health and with support from competent supervisors that help them navigate these feelings.

Given that adding new curriculum or courses might be difficult for some training programs, participants suggested incorporating these opportunities into current active courses. For example, some of the participants suggested incorporating a dialogue about sexual health into the multicultural course when discussing how to engage in difficult dialogues. Additionally, they suggested acquiring the general knowledge in courses such as lifespan development or couple and family therapy courses. The opportunity to acquire the sexual health skills

competency was suggested to occur through role playing or modeling opportunities in the basic clinical skills courses or in clinical placements. Lastly, suggestions were made that clinical placements might provide trainees with learning opportunities to assist diverse clients to influence the topics discussed in supervision. Future professionals would benefit from incorporating these suggestions into their training programs to better prepare future counseling psychologists in addressing sexual health needs of clients. This would further assist future professionals with feeling more adequately prepared and potentially comfortable in their future experiences with clients. This reveals the importance of graduate training curriculum and clinical placement support in building sexual health competency for future trainees.

This study also lends credence to the importance of incorporating sex-positive tenants into future sexual health training for counseling psychologists. Although some of the participants were unfamiliar with a sex-positive framework, the counseling psychology values that drive their practice posed similarities to values of a sex-positive approach. Those unfamiliar with the term felt connected to a sex-positive framework once provided with a brief definition from the literature. Specifically, participants discussed the importance of approaching client sexual health needs from an open, nonjudgmental nature that encourages sexual flourishing and wellbeing. However, many indicated discomfort and avoidance of inquiring about a client's current sexual functioning or satisfaction. They identified the benefit, and connectedness with its value, to inquiring about this with clients but felt unprepared and incompetent on how to proceed with the discussion. This was especially true for participants in settings such as integrated pediatric primary care and the military where certain topics of sexual health were noted to be less acceptably discussed. Practical considerations for setting specific trainings might guide professionals in how to best address these topics with clients through a sex-positive framework.

This highlights how just as incorporating sexual health training into programs is important, so is the approach that frames sexual health training foundation. These experiences suggest that graduate training programs should further explore using a sex-positive framework to guide future sexual health training within graduate training programs.

Recommendations for Future Research

Currently, the literature on counseling psychologists' experiences in addressing client sexual health needs is scarce. The results from this study suggest that further research is needed to understand counseling psychologists' experiences in addressing sexual health needs of clients. Future research specifically needs to understand the variability of counseling psychologists' experiences and their understanding of sexual health by adding diversity and depth amongst participate responses. Through the development of this research, a tangible and usable definition of sexual health can be developed to incorporate into the foundation of sexual health competency for graduate training programs. Given that half of the participants struggled to define sexual health competency, this would aid in building a foundation to incorporate into graduate training programs. Clinicians have acknowledged there is an absence of sexual health training within their graduate programs. Therefore, future research might use mixed methodologies to assess the current sexual health training practices that are generally used in graduate training programs. As a result, this might aid in the development of standardized training goals that mirror the competency standards of building a trainee's knowledge, awareness, and skills in sexual health. Perhaps some of the educational opportunities suggested by previous literature and participants of this study might be put into practice and assessed for their effectiveness in building a trainee's sexual health competency. Further, this research might also assess its implications for

professionals' level of comfort and willingness to address sexual health needs of clients if their competency has been considered and supported by training programs.

Further, counseling psychologists in this study acknowledged feeling unsupported by the general field of psychology and its professional governing body. Previous literature and the participants in the study recognized an absence of general professional dialogue about sexual health. Specifically, they recognized the utility of creating awareness about the importance of the dialogue from professional organizations. Perhaps future research might assess the current state of professional organizational focus on sexual health and assess its implications for dialogue amongst professionals. The participants in this study suggested incorporating webinars or creating listserv conversations about sexual health might increase awareness and comfort with the topic. Therefore, future research might implement some of these suggestions and assess its overall effectiveness in opening a professional dialogue and aiding with competency.

Additionally, previous research and participant experiences from this study also highlighted an absence of sexual health continuing educational opportunities. Given that continuing education is used to promote growth and create awareness of relevant psychological topics, inclusivity of sexual health might benefit professionals' competency where its lacking. Providing these opportunities and assessing their effectiveness for professionals might be another beneficial avenue for future research. With increased recognition, research might prompt the development of sexual health guidelines for the American Psychological Association to benefit the field of psychology as a whole. These research endeavors highlight the need for professional support of the importance of strengthening sexual health competency and recognition within the field.

Final Remarks

The primary focus of the study was to understand the experiences of counseling psychologists' in addressing sexual health needs of clients through a sex-positive framework. The results of this study inform the professional field of psychology and graduate psychology training programs that support the development of future trainees. These individual experiences highlight the need for trainees to feel supported by their training programs by being offered opportunities to build their competencies of various phenomenon's. This study reminds us how the social context has the power to shape and transform the foundation of graduate training, and inevitably the competency of professionals. These psychologists' experiences are significant, as they demonstrate the need for training programs to incorporate a breadth of topics into their training curriculums, in particular sexual health.

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APPENDICIES

APPENDIX A:

Recruitment Email

Counseling Psychologists' Experiences in Addressing Sexual Health with Clients: A Sex Positive Perspective

What is the purpose of the study?

I want to understand the experiences of counseling psychologists in assisting their clients with sexual health needs.

Who is eligible to participate?

I am interested in interviewing licensed counseling psychologists.

What will I be doing?

You will complete an in-person or video interview. Questions will focus on (a) counseling psychology values, (b) professional experiences with sexual health, (c) graduate training experiences in sexual health, and (d) value influences related to sexual health. Prior to the interview you will be asked to complete a demographic questionnaire and a case study questionnaire that asks you to reflect on a prior experience in assisting a client with their sexual health needs.

How long is a session? One hour and the potential for additional time if necessary for clarification following the interview. The demographic questionnaire and case study questionnaire will take about 30 minutes to complete.

When and where?

You will be asked to participate in person at an agreed upon location OR through the use of video interview using your office or home computer.

Interested in participating?

Please reply to this email with your contact information or call me at (812) 899-0293. I'll give you a call or email to ask you some questions to help us determine if you qualify for the study.

Participation is completely voluntary and participant data can be removed from the study at any time upon the request of the participant.

If you have any questions, please contact me at jwatjen@uwm.edu or Dr. Nadya Fouad at nadya@uwm.edu or (414) 229-6830.

Thank you for interest,

Jennifer Watjen
Counseling Psychology Doctoral Student
Department of Educational Psychology
University of Wisconsin - Milwaukee

APPENDIX B:

Informed Consent

Study title	Counseling Psychologists' Experiences Addressing Sexual Health of Clients: A Sex Positive Perspective
Researcher[s]	Nadya Fouad, Ph.D. & Jennifer Watjen, Educational Psychology Department

We're inviting you to participate in a research study. Participation is completely voluntary. If you agree to participate now, you can always change your mind later. There are no negative consequences, whatever you decide.

What is the purpose of this study?

We want to understand the experiences of counseling psychologists in assisting their clients with sexual health needs.

What will I do?

You will complete an in-person or video interview. Questions will focus on (a) counseling psychology values, (b) professional experiences with sexual health, (c) graduate training experiences in sexual health, and (d) value influences related to sexual health. The total time will be about 60 minutes. Prior to the interview you will be asked to complete a demographic questionnaire and a case study questionnaire that asks you to reflect on a prior experience in assisting a client with their sexual health needs. You will be sent a link to complete the questionnaires on Qualtrics once you have been screened to participate. These questionnaires will take approximately 30 minutes to complete. The questionnaire will be completed at least two days prior to the scheduled interview. Child/minor experiences will not be reported in the case study questionnaire or interview.

Risks

Possible risks	How we're minimizing these risks
Some questions may be very personal or upsetting.	<ul style="list-style-type: none">You can skip any questions you don't want to answer.
Breach of confidentiality (your data being seen by someone who shouldn't have access to it).	<ul style="list-style-type: none">We'll store all electronic data on a password-protected, encrypted computer.We'll store all paper data in a locked filing cabinet in a locked office.We'll keep your identifying information separate from your research data, but we'll be able to link it to you by using a study ID. We will destroy this link after we finish collecting and analyzing the data.
Interception of online data.	<ul style="list-style-type: none">This is a risk you experience any time you provide information online. We're using a secure online system to collect this data, but we can't completely eliminate this risk.

There may be risks we don't know about yet. Throughout the study, we'll tell you if we learn anything that might affect your decision to participate.

Other Study Information

Possible benefits	Help understand counseling psychologists' experiences in assisting clients to aid with future training.
Estimated number of participants	10-15 licensed counseling psychologists
How long will it take?	~1 hour for the interview and ~ 30 minutes for the questionnaires
Costs	None
Compensation	None
Future research	De-identified (all identifying information removed) data may be shared with other researchers. You won't be told specific details about these future research studies.
Recordings / Photographs	We will audio record you. The audio recordings will be used to transcribe the data and draw conclusions. The audio recording is necessary to this research. If you do not want to be audio recorded, you should not be in this study.

What if I am harmed because I was in this study?

If you're harmed from being in this study, let us know. If it's an emergency, get help from 911 or your doctor right away and tell us afterward. We can help you find resources if you need psychological help. You or your insurance will have to pay for all costs of any treatment you need.

Confidentiality and Data Security

We'll collect the following identifying information for the research: your name and email address. This information is necessary so that the researchers can follow-up for any clarifying questions regarding your interview.

Where will data be stored?	On our locked computers and in a locked office at UWM.
How long will it be kept?	7 years following the completion of the study.

Who can see my data?	Why?	Type of data
The researchers	To analyze the data and conduct the study	<ul style="list-style-type: none"> • Coded (names removed and replaced with a study ID)
The IRB (Institutional Review Board) at UWM The Office for Human Research Protections (OHRP) or other federal agencies	To ensure we're following laws and ethical guidelines	<ul style="list-style-type: none"> • De-identified (no names, birthdate, address, etc.)
Anyone (public)	If we share our findings in publications or presentations	<ul style="list-style-type: none"> • De-identified (no names, birthdate, address, etc.)

		<ul style="list-style-type: none"> • If we quote you, we'll use a pseudonym (fake name)
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Contact information:

For questions about the research	Nadya Fouad, Ph.D. Jennifer Watjen	Nadya@uwm.edu, (414) 229-6830 Jwatjen@uwm.edu
For questions about your rights as a research participant	IRB (Institutional Review Board; provides ethics oversight)	414-229-3173 / irbinfo@uwm.edu
For complaints or problems	Nadya Fouad, Ph.D. Jennifer Watjen	Nadya@uwm.edu, (414) 229-6830 Jwatjen@uwm.edu
	IRB	414-229-3173 / irbinfo@uwm.edu

Signatures

If you have had all your questions answered and would like to participate in this study, sign on the lines below. Remember, your participation is completely voluntary, and you're free to withdraw from the study at any time.

Name of Participant (print)

Signature of Participant

Date

Name of Researcher obtaining consent (print)

Signature of Researcher obtaining consent

Date

APPENDIX C:

Paradigm Case Questionnaire

Directions: Take 10-15 minutes to respond to each of the questions below about your experiences assisting clients with their sexual health needs. Do not put your name on this form, as your responses are confidential.

Think back over the course of your professional career as a licensed counseling psychologist. Choose a positive or negative event that you experienced in assisting a client with their sexual health needs. The event should be one that caused you to reflect on how you managed the situation and that might have visibly impacted the client. This event should be one that is memorable within your career. Write some notes about this incident and include the following details:

1. What was the background of the client?
2. What occurred during this incident?
3. When and where did this incident occur?
4. Who was involved in the incident? (Do not provide any identifiable information of the client)
5. What was it about the incident that was so memorable to you?

APPENDIX D:
Demographic Questionnaire

To be completed by the interviewer:

Participant ID#: _____

Interview Date: _____

To be completed by the participant:

1. Age: _____
2. Race/Ethnicity: _____
3. Gender: _____
4. University for Master's Training: _____
5. University for Doctoral Training: _____
6. Current State of Practice: _____
7. Number of Years Working as a Psychologist: _____
8. Current Professional Work Setting: _____

APPENDIX E:

Interview Questions

Research Questions	Interview Questions
<p>1. What have counseling psychologists experienced in assisting clients with their sexual health?</p> <p style="padding-left: 20px;">a) How do counseling psychologists feel about their competency in sexual health to assist clients?</p>	<p>1. Can you tell me about your past and current professional experiences as a licensed counseling psychologist?</p> <p>2. How does the topic of sexual health connect to the field of counseling psychology?</p> <p>3. How do you feel about your ability to assist clients with their sexual health?</p>
<p style="padding-left: 20px;">b) What role do counseling psychology values play in the experiences of counseling psychologists in assisting clients with their sexual health?</p>	<p>4. Can you tell me what it means to you to be a counseling psychologist?</p> <p>5. What values connect you with the field of counseling psychology?</p>
<p style="padding-left: 20px;">c) What meaning do counseling psychologists apply to a sex-positive framework?</p>	<p>6. How would you define sexual health competency, as it applies to psychologists?</p> <p>7. What skills do psychologists need to possess in order to be competent in sexual health?</p> <p style="padding-left: 20px;">a. Where do you think they can acquire these skills?</p> <p>8. How comfortable do you feel in discussing sexual health with your clients?</p> <p style="padding-left: 20px;">a. What affects your level of comfort discussing this topic?</p> <p>9. In your clinical experiences, how often do you discuss sexual health with your clients?</p> <p style="padding-left: 20px;">a. What was the nature of those discussions?</p> <p>10. What does it mean to use a sex-positive framework for discussing sexual health?</p>

	<p>a. Does this framework connect with counseling psychology?</p>
<p>d) What experiences have counseling psychologists had with sexual health training within their graduate programs and outside of their programs?</p>	<ol style="list-style-type: none"> 1. At this point in your career, do you feel sexual health has been addressed in your educational and clinical training experiences? 2. How often was sexual health discussed within your graduate courses or clinical training opportunities? <ol style="list-style-type: none"> a. What was the nature of those discussions? 3. How many continuing education or training opportunities have you attended that focused on sexual health? <ol style="list-style-type: none"> a. What topics were discussed? b. How helpful were these opportunities? 4. What types of educational opportunities would benefit your sexual health training? 5. Have these training experiences impacted your feelings of competency in sexual health?
<p>e) What role does the counseling psychologists' personal values play in assisting clients with their sexual health?</p>	<ol style="list-style-type: none"> 1. How does your background influence your work in assisting clients with their sexual health? 2. How might a psychologists' values of sexual health affect their work with clients? <ol style="list-style-type: none"> a. What are some of your personal values that might influence your work in assisting clients with sexual health?

APPENDIX F:

Initial Inter-Codal Agreement

List Themes with Code Numerals -- Developed by 1st Coder (Primary Investigator)

1. Absence of training
2. Ability increased
3. Comfort increased
4. Sexual health conversations
5. Connected values (CP/sex-positive)
6. Presence of discomfort
7. Feelings of incompetence
8. Absence of continuing education
9. Absence of competent supervision
10. Relevance of personal identities/values
11. Educational suggestions
12. Sex-positive framework defined
13. Sexual health competency
14. Social influence
15. Counseling psychology values

Additional Themes:

Notes & Overall Impressions:

Theme**Theme Definition****Exemplar Quote**

		“The only times I remember talking about it are with the visiting faculty person that I mentioned, and that wasn't it because like we read something about it, it wasn't like the topic of it wasn't like in
		“And then and I think maybe making you know half of the class sort of content or knowledge specific and then half of the class like clinical skills. That would have been great.”
		“...so, it was conspicuously not talked about and I remember being aware of that but then also having almost all male straight male supervisors I also like kind of avoided it and I didn't really know how to or really wanted to talk about the fact that I wasn't talking about sex with my male clients with my male supervisors.”
		“I think I am certainly much more comfortable now than there was earlier in my training.”
		“I think having a supervised field placement experience in sex and sexual health. And I think you don't need a specific setting to do that and you don't need a specific population you just need a competent supervisor to ask the questions.”
		“I can say that like my I've certainly had my own journey around sex and, and relationships, and my own sexuality.”
		“...view people within the context of their environment. You look at their strengths and their culture and their background and more phenomenological.”
		“I feel pretty comfortable. Probably, because everything comes over time.”
		“...it's probably a big counselling psychology thing not only viewing it from the point of view of the damage it's done from my patient, to my patient, but also how can we use this knowledge to rise it up a level, and how do we view it from a broader cultural lens, and get involved in things like the allegations committee for this dioceses and professional organizations to raise awareness.”

		“...knowledge, attitudes, and skills right, in terms of competencies, so certainly knowledge is needed about the issues of the day, really. You know if those issues include child trafficking patterns in your community or knowledge about how AIDS is transmitted or knowledge about, knowledge about positive sexual interactions and the ability to say no and what does full consent mean.”
		“I may be a little bit less explicit than I was when I was younger because it's kind of like talking to your mom.”
		“You know I'd have to say if I have a bias that I, don't think I show, I try not to show, but, but I think my bias is that sex within the context of a relationship is healthier.”
		“I think probably the biggest shaper of that is being an adopted person.”
		“There were no classes. There were no explicit, but you know I'm going to guess but I don't have any explicit memories that you know when we did roll plays in introductory counseling.”
		“In terms of stuff that involved a syllabus and you know particular readings, no there was nothing.”
		“I think very early on I wasn't as comfortable with gay sexuality.”
		“I think more it's more attitudinal and so working with clients who are different than you would be something that if I was in a training position that I would be prone to want practicum students to do.”
		“Sort of being able to talk about sexual matters without shame.”
		“Well that sort of the attitude of Counseling Psychology in general which would be an openness to the phenomenological experience of a client within the context of their community culture and family, not just looking for a pathological checklist of symptoms.”
		“I like the wellness focus, the developmental focus, looking at how do we help enhance lives.”

		“I definitely feel like I didn't get enough training in it like in, in grad school it was not a clear focus. I think I've had to do a lot of training since then.”
		“...right now I think maybe half my caseload are women that are working on like the acceptance parts of it and like how do I figure out what is it that that I feel about sexuality versus what other people have told me and like wanting to develop like a healthier more comfortable relationship with their sexuality.”
		“...being comfortable with the vocabulary and the anatomy and just all of that stuff and really figuring out like where, what are your own values and really realizing that those are just personal or values and, and making sure you're not kind of projecting that out on to others.”
		“I think it came through just being, being in my internships and realizing like how, how many clients this was sort of an issue.”
		“Like there was one human sexuality class you could take as an elective during my grad program but in the five years I was there it was offered only one time and it conflicted with internships so I couldn't take it.”
		“I do know there's ways that I wish that I had access to more supervision around these things in practice, but a lot of my supervisors weren't necessarily, didn't necessarily know more about it than I did.”
		“I get a lot of clients too that have they come from pretty repressive sort of religious backgrounds and really have internalized a lot of these things like I don't cognitively believe that I'm dirty if I do this but I got a lot of messages about sex being dirty or sex being something that bad girls do or sex being.”
		“I mean so being aware of like a sex guidelines and stuff.”
		“I think for me like competency it's like the general like do you have knowledge awareness and skills.”
		“...coming at it from a place of assuming this is a source of strength and fulfillment in life and then figuring out how do we help folks explore that.”

		“I don't really have a supervisor that I can go to and say like you know what about this.”
		And then thinking about like dating and how to access this and how do I get what I want, I talk about relationship boundaries and how yeah consent around those things.
		“...she would have sex even if she was on the pill and using a condom, she was like obsessed that she was pregnant she would take like a million pregnancy tests. But she also had like in our discussion, she was so anxious when having sex like she never had an orgasm.”
		“...for me it's a lot of like helping them notice like what's coming up for them and developing comfort.”
		“I also came from a very repressive background, like super evangelical like very much purity culture, all of those things.”
		“...feminism helped me a lot too right.”
		“...having that like yeah increase in that conversation. I mean maybe we need Division 17 to do a whole year of webinars on sexual health or you know doing those sorts of things.”
		“I mean sometimes we talk about consent, sometimes we talk about safer sex practices.”
		“...to accept like folks wherever they are and to help them figure out like why are there yeses and why are their no's, no's.”
		“...are your desire or issues related, and then it really does the great thing of like combating shame and normalizing our, our fantasies”
		“...it's this idea that I think all of us are entitled to like a beautiful safe and comfortable relationship with our body and our sexuality whatever it is that we want or don't want.”
		“Very minimally. In my graduate program, very minimally. A little bit, you know, in couples and family class a little bit in maybe one of my internship classes.”
		“I think a lot of stuff around sex has come up because of like Me Too going on, and like I know when the Kavanaugh hearings were happening.”

		“I think for me one like so having been raised in a really explicitly anti-sex upbringing like a very, very repressive.”
		“...because it is taboo to talk about this.”
		“We just need to be talking about it. I think that's like step 1 and then but yeah. And since we're talking about it using like the current research.”
		“...I don't have specific training and I've never done even a two-day training to my recollection.”
		“I'm not particularly shy or modest just in my general personality.”
		“I guess we would think of it in the strengths model so it's one of many parts of a human being.”
		“...certain jobs that we do ask very specifically about pornography use and visiting prostitutes because those are two things that can lead to. It can indicate poor judgment.”
		“Talking about masturbation a little bit (uncomfortable). I hesitate a little because I don't want to turn them off.”
		“As far as current sex though, I guess I'm not as comfortable just saying, how's your current sex life?”
		“And I think that would be less of a lecture topic and more of a group discussion.”
		“I guess it definitely could've been better no question with your questions I'm realizing I haven't had any formal training.”
		“I get their culture a little bit more to where that helps me to know I could ask a guy you know I could ask one of the military members and they'd probably tell me they probably wouldn't be disgusted by it.”
		“I feel like me and my colleagues have always been a little uncomfortable with the erectile dysfunction piece or am I thinking. Yeah, that, we barely see the premature ejaculation...”
		“I'm wondering if it's treating sex as a skill and like a thing that can be maximized for patients and make them healthier...”

		“So, I guess even in a healthy person it doesn't have any complaints about sex it would be sex would still be relevant...”
		“I mean you're battling like just general social norms to talking about this is.”
		“I think that would be great to have some training if there was one, I would definitely go. I've never avoided it. I just cannot think of one that's ever been offered to me.”
		“...the biggest thing is just the training that I've gotten in being able to really have a systemic approach.”
		“And I think as I've worked here its increased my level of comfort.”
		“Every patient who completes an initial evaluation over the age of 11 we inquire about their sexual history...”
		“You know as an as an Asian Indian I grew up and my parents we don't talk about sex we didn't talk by any of those kinds of things.”
		“...I think there's another layer of like a personal level of comfort and really exploring kind of your level of comfort with it. And then the next piece is like how do you effectively deliver this...”
		“...what we bring to it I think is important but also what our history and our own experiences of sexual health and conversations about it also are important to understand and recognize.”
		“...observing other people ask the questions, fine tuning how I ask the question.”
		“I think there are some unique competencies and skill set when you're when you are interviewing and interacting with younger you know pediatric patients versus adult patients.”
		“We might have some in development in like our life span development class we may have talked a little bit about it but other than that I can't remember specifically talking about and learning about sexual health.”
		“I developed a confidence and competency in this over the course of this, this career, you know this current job.”

		“I think it could be incorporated into having a difficult conversation.”
		“I think to me it's this idea of how do we support family patient family's kind of system where they are and while also incorporating all aspects of their life.”
		“...I had to kind of learn how do I how do I talk about this with patients who are not my biological children...”
		“...I think some of it, it was like of being thrown at the deep end of the pool with no floaties and I just had to figure out how to swim...”

APPENDIX G:

Final Inter-Codal Agreement

Principal Investigator	Research Auditor	Exemplar Quote
Absence of training and supervision	Absence of training and supervision	“The only times I remember talking about it are with the visiting faculty person that I mentioned, and that wasn't it because like we read something about it, it wasn't like the topic of it wasn't like in the syllabus.”
Educational suggestions	Educational suggestions	“And then and I think maybe making you know half of the class sort of content or knowledge specific and then half of the class
Absence of training and supervision	Absence of training and supervision	“...so, it was conspicuously not talked about and I remember being aware of that but then also having almost all male straight male supervisors I also like kind of avoided it and I didn't really know how to or really wanted to talk about the fact that I wasn't talking about sex with my male clients with my male supervisors.”
Comfort increased	Comfort increased	“I think I am certainly much more comfortable now than there was earlier in my training.”
Educational Suggestions	Educational Suggestions	“I think having a supervised field placement experience in sex and sexual health. And I think you don't need a specific setting to do that and you don't need a specific population you just need a competent supervisor to ask the questions.”
Relevance of personal identities/values	Relevance of personal identities/values	“I can say that like my I've certainly had my own journey around sex and, and relationships, and my own sexuality.”
Comfort increased	Comfort increased	“I feel pretty comfortable. Probably, because everything comes over time.”
Sex-positive framework defined	Sex-positive framework defined	“...it's probably a big counselling psychology thing not only viewing it from the point of view of the damage it's done from my patient, to my patient, but also how can we use this knowledge to rise it up a level, and how do we view it from a broader cultural lens, and get involved in things like the allegations

		committee for this dioceses and professional organizations to raise awareness.”
Connection of counseling psychology values to sexual health	Connection of counseling psychology values to sexual health	“...knowledge, attitudes, and skills right, in terms of competencies, so certainly knowledge is needed about the issues of the day, really. You know if those issues include child trafficking patterns in your community or knowledge about how AIDS is transmitted or knowledge about, knowledge about positive sexual interactions and the ability to say no and what does full consent mean.”
Relevance of personal identities/values	Relevance of personal identities/values	“I may be a little bit less explicit than I was when I was younger because it's kind of like talking to your mom.”
Relevance of personal identities/values	Relevance of personal identities/values	“You know I'd have to say if I have a bias that I, don't think I show, I try not to show, but, but I think my bias is that sex within the context of a relationship is healthier.”
Relevance of personal identities/values	Relevance of personal identities/values	“I think probably the biggest shaper of that is being an adopted person.”
Absence of training and supervision	Absence of training and supervision	“There were no classes. There were no explicit, but you know I'm going to guess but I don't have any explicit memories that you know when we did roll plays in introductory counseling.”
Absence of training and supervision	Absence of training and supervision	“In terms of stuff that involved a syllabus and you know particular readings, no there was nothing.”
Relevance of personal identities/values	Relevance of personal identities/values	“I think very early on I wasn't as comfortable with gay sexuality.”
Educational suggestions	Educational suggestions	“I think more it's more attitudinal and so working with clients who are different than you would be something that if I was in a training position that I would be prone to want practicum students to do.”
Sexual health competency	Sexual health competency	“Sort of being able to talk about sexual matters without shame.”

Sex-positive framework defined	Sex-positive framework defined	“I like the wellness focus, the developmental focus, looking at how do we help enhance lives.”
Absence of training and supervision	Absence of training and supervision	“I definitely feel like I didn't get enough training in it like in, in grad school it was not a clear focus. I think I've had to do a lot of training since then.”
Sexual health conversations	Sexual health conversations	“...right now I think maybe half my caseload are women that are working on like the acceptance parts of it and like how do I figure out what is it that that I feel about sexuality versus what other people have told me and like wanting to develop like a healthier more comfortable relationship with their sexuality.”
Sexual health competency	Sexual health competency	“...being comfortable with the vocabulary and the anatomy and just all of that stuff and really figuring out like where, what are your own values and really realizing that those are just personal or values and, and making sure you're not kind of projecting that out on to others.”
Absence of training and supervision	Absence of training and supervision	“Like there was one human sexuality class you could take as an elective during my grad program but in the five years I was there it was offered only one time and it conflicted with internships so I couldn't take it.”
Absence of training and supervision	Absence of training and supervision	“I do know there's ways that I wish that I had access to more supervision around these things in practice, but a lot of my supervisors weren't necessarily, didn't necessarily know more about it than I did.”
Educational suggestions	Educational suggestions	“I mean so being aware of like a sex guidelines and stuff.”
Sexual health competency	Sexual health competency	“I think for me like competency it's like the general like do you have knowledge awareness and skills.”
Sex-positive framework defined	Sex-positive framework defined	“...coming at it from a place of assuming this is a source of strength and fulfillment in life and then figuring out how do we help folks explore that.”

Absence of training and supervision	Absence of training and supervision	“I don't really have a supervisor that I can go to and say like you know what about this.”
Sex-positive framework defined	Sex-positive framework defined	And then thinking about like dating and how to access this and how do I get what I want, I talk about relationship boundaries and how yeah consent around those things.
Sexual health conversations	Sexual health conversations	“...she would have sex even if she was on the pill and using a condom, she was like obsessed that she was pregnant she would take like a million pregnancy tests. But she also had like in our discussion, she was so anxious when having sex like she never had an orgasm.”
Sexual health conversations	Sexual health conversations	“...for me it's a lot of like helping them notice like what's coming up for them and developing comfort.”
Relevance of personal identities/values	Relevance of personal identities/values	“I also came from a very repressive background, like super evangelical like very much purity culture, all of those things.”
Relevance of personal identities/values	Relevance of personal identities/values	“...feminism helped me a lot too right.”
Educational suggestions	Educational suggestions	“...having that like yeah increase in that conversation. I mean maybe we need Division 17 to do a whole year of webinars on sexual health or you know doing those sorts of things.”
Sexual health conversations	Sexual health conversations	“I mean sometimes we talk about consent, sometimes we talk about safer sex practices.”
Sex-positive framework defined	Sex-positive framework defined	“...to accept like folks wherever they are and to help them figure out like why are there yeses and why are their no's, no's.”
Sex-positive framework defined	Sex-positive framework defined	“...it's this idea that I think all of us are entitled to like a beautiful safe and comfortable relationship with our body and our sexuality whatever it is that we want or don't want.”
Absence of training and supervision	Absence of training and supervision	“Very minimally. In my graduate program, very minimally. A little bit, you know, in couples and family class a little bit in maybe one of my internship classes.”

Relevance of personal identities/values	Relevance of personal identities/values	“I think for me one like so having been raised in a really explicitly anti-sex upbringing like a very, very repressive.”
Educational suggestions	Educational suggestions	“We just need to be talking about it. I think that's like step 1 and then but yeah. And since we're talking about it using like the current research.”
Absence of training and supervision	Absence of training and supervision	“...I don't have specific training and I've never done even a two-day training to my recollection.”
Relevance of personal identities/values	Relevance of personal identities/values	“I'm not particularly shy or modest just in my general personality.”
Sex-positive framework defined	Sex-positive framework defined	“I guess we would think of it in the strengths model so it's one of many parts of a human being.”
Sexual health conversations	Sexual health conversations	“...certain jobs that we do ask very specifically about pornography use and visiting prostitutes because those are two things that can lead to. It can indicate poor judgment.”
Presence of discomfort	Presence of discomfort	“Talking about masturbation a little bit (uncomfortable). I hesitate a little because I don't want to turn them off.”
Presence of discomfort	Presence of discomfort	“As far as current sex though, I guess I'm not as comfortable just saying, how's your current sex life?”
Educational suggestions	Educational suggestions	“And I think that would be less of a lecture topic and more of a group discussion.”
Absence of training and supervision	Absence of training and supervision	“I guess it definitely could've been better no question with your questions I'm realizing I haven't had any formal training.”
Relevance of personal identities/values	Relevance of personal identities/values	“I get their culture a little bit more to where that helps me to know I could ask a guy you know I could ask one of the military members and they'd probably tell me they probably wouldn't be disgusted by it.”
Presence of discomfort	Presence of discomfort	“I feel like me and my colleagues have always been a little uncomfortable with the erectile dysfunction piece or am I thinking. Yeah, that, we barely see the premature ejaculation...”

Sex-positive framework defined	Sex-positive framework defined	“I'm wondering if it's treating sex as a skill and like a thing that can be maximized for patients and make them healthier...”
Absence of training and supervision	Absence of training and supervision	“I think that would be great to have some training if there was one, I would definitely go. I've never avoided it. I just cannot think of one that's ever been offered to me.”
Educational suggestions	Educational suggestions	“...the biggest thing is just the training that I've gotten in being able to really have a systemic approach.”
Comfort increased	Comfort increased	“And I think as I've worked here its increased my level of comfort.”
Sexual health conversations	Sexual health conversations	“Every patient who completes an initial evaluation over the age of 11 we inquire about their sexual history...”
Relevance of personal identities/values	Relevance of personal identities/values	“You know as an as an Asian Indian I grew up and my parents we don't talk about sex we didn't talk by any of those kinds of things.”
Sexual health competency	Sexual health competency	“...I think there's another layer of like a personal level of comfort and really exploring kind of your level of comfort with it. And then the next piece is like how do you effectively deliver this...”
Relevance of personal identities/values	Relevance of personal identities/values	“...what we bring to it I think is important but also what our history and our own experiences of sexual health and conversations about it also are important to understand and recognize.”
Educational suggestions	Educational suggestions	“...observing other people ask the questions, fine tuning how I ask the question.”
Sexual health competency	Sexual health competency	“I think there are some unique competencies and skill set when you're when you are interviewing and interacting with younger you know pediatric patients versus adult patients.”
Absence of training and supervision	Absence of training and supervision	“We might have some in development in like our life span development class we may have talked a little bit about it but other than that I can't remember specifically talking about and learning about sexual health.”

Comfort increased	Comfort increased	“I developed a confidence and competency in this over the course of this, this career, you know this current job.”
Educational suggestions	Educational suggestions	“I think it could be incorporated into having a difficult conversation.”
Presence of discomfort	Presence of discomfort	“...I think some of it, it was like of being thrown at the deep end of the pool with no floaties and I just had to figure out how to swim...”

CURRICULUM VITAE

Jennifer Watjen

EDUCATION

University of Wisconsin-Milwaukee (APA Accredited) Expected Graduation August 2020 Doctor of Philosophy in Educational Psychology (Counseling Psychology)	Milwaukee, WI. GPA: 3.91
Roosevelt University (CACREP Accredited) August 2014 Master of Arts (Clinical Professional Psychology)	Chicago, IL. GPA: 3.93
Eastern Kentucky University December 2010 Bachelor of Science (Psychology), Minor (Women and Gender Studies)	Richmond, KY. GPA: 3.87

CLINICAL EXPERIENCE

<i>Pre-Doctoral Psychology Internship</i> University of Texas Health Science Center at San Antonio Kerrville State Hospital, forensic state hospital Supervisors: Michael Jumes, Ph.D. & Billy James, Ph.D.	07/2019 – 07/2020 San Antonio, TX
<ul style="list-style-type: none">○ Facilitate individual therapy with forensic patients primarily presenting with severe, persistent mental illness and mood disorders.○ Complete psychological intakes on newly admitted patients for diagnostic clarification and treatment recommendations for the treatment team.○ Participate in weekly treatment team meetings to review patients' treatment plans and progress.○ Conduct group therapy for forensic patients on topics such as forgiveness and making amends, mood management, and competency restoration.○ Complete psychological evaluations for county dispatchers and police officers seeking employment.○ Perform competency evaluations and write reports for the courts for patients who have been deemed Incompetent to Stand trial.○ Complete violence risk assessments and write court reports for patients who have been adjudicated Not Guilty by Reason of Insanity (NGRI).○ Attend regular didactic trainings on topics such as psychopharmacology, violence risk assessments, forensic report writing, forensic psychology, etc.○ Conduct research for quality improvement of treatment team decision-making processes.○ Lead regular trainings for new employees about mental health education.○ Co-lead a weekly Dialectical Behavior Therapy group for community members in an outpatient community mental health center.○ Facilitate individual therapy for community members in an advanced community clinic.	

Mental Health Professional

06/2018 – 06/2019

Wexford Health Sources, Inc., Wabash Valley Correctional Facility

Carlisle, IN.

Maximum security prison serving adult male inmates

Supervisor: Mary Sims, Ph.D.

40 hours per week

- Carry a caseload of 70-80 adult male clients from various cultural and ethnic backgrounds.
- Facilitate individual therapy with inmates in general population and the Special Needs Unit with presenting concerns including severe, persistent mental illness, adjusting to incarceration, depression, anxiety, grief and loss, and mood dysregulation.
- Complete psychological intakes on newly admitted inmates in general population and the Special Needs Unit to determine future mental health needs and classifying them according to need.
- Conduct crisis interventions, suicide risk assessments, suicide watch contacts, and post suicide-watch reports and follow-ups.
- Participate in weekly review of inmates in the Restrictive Housing Unit to review stability and management of safety.
- Manage weekly rounds to assess the stability and safety of seriously mentally ill (SMI) inmates in the Restricted Housing Unit.
- Assist correctional staff in dialoguing with uncooperative and hostile inmates in order to obtain compliance and avoid physical confrontation.
- Consult with unit management about inmate stability and containment of risk.
- Participate in weekly meetings with psychology staff to consult on cases and address facility needs.
- Write referrals for psychiatric consultation about reported medication side effects or other medication concerns.
- Provide structured group therapy with inmates on topics such as anger management, life skills for lower intellectual level clients, and grief and loss.
- Train staff in suicide prevention and trauma informed care practices at the facility.

Doctoral Practicum Extern

09/2017 – 05/2018

Taycheedah Correctional Institute

Fond du Lac, WI.

Maximum/medium security prison serving adult female detainees

Supervisor: Jessica Anderson, Psy.D.

16-20 hours per week

- Provided individual therapy to 10 culturally diverse inmates residing in general population and Restricted Housing Units with a range of acute and chronic cognitive, emotional, and personality disorders.
- Completed psychological assessments for diagnostic clarification and treatment rationale upon the request of psychological service and health service staff.
- Psychological assessments utilized, but not limited to, included the Wechsler Adult Intelligence Scale-IV (WAIS-IV), the Minnesota Multiphasic Personality Inventory- II (MMPI-2), the Personality Assessment Inventory (PAI), the Validity Indicator Profile (VIP), the Test of Memory Malingering, and the Trauma Symptom Inventory (TSI).

- Scored and interpreted all assessment and interview information to complete integrated reports for treatment purposes of clients that completed comprehensive psychological assessments.
- Collaborated with facility correctional, medical, and educational staff to determine appropriate treatment practices for clients.
- Facilitated group therapy for clients in Restricted Housing Units on topics pertaining to coping skills, emotional management, and cognitive techniques.
- Consulted with psychological service staff to identify extended treatment needs at the Wisconsin Resource Center for clients with severe mental illness and substance use disorders.
- Participated in weekly individual and group supervision with a licensed psychologist to consult on client cases and participate in didactic trainings.

Qualified Mental Health Professional/Doctoral Practicum Extern
Advanced Correctional Healthcare, Fond du Lac County Jail
Pre-trial correctional facility and detention center

08/2016 – 05/2018
 Fond du Lac, WI.

Supervisor: Melissa Caldwell, Ph.D.

32 hours per week

- Provided therapy to 150-200 culturally diverse clients with presenting concerns including but not limited to coping with incarceration, trauma, grief, substance abuse, emotion regulation, relationship issues, and career guidance.
- Completed suicide risk assessments, suicide watch contacts, and post suicide-watch reports and follow-ups.
- Assessed mental well-being, potential risk to self, and suicidality of detainees through individual therapy, segregation rounds, and brief interventions.
- Intervened with in-crisis detainees to ensure well-being and safety.
- Consulted with security regarding best housing of detainees with significant mental health needs.
- Collaborated with medical staff to determine best treatment of detainees including housing and potential administration of medication.
- Developed and facilitated a weekly anger management group for male detainees.
- Referred mentally unstable detainees to outside housing and treatment to ensure safety and continuity of treatment.
- Coordinated with county mental health and the public health department for continuity of care and discharge planning for detainees.
- Assisted in the referral process of detainees involved in the public health department's Vivitrol program.
- Discussed developing challenges at facility during quarterly staff meetings.
- Facilitated staff training on mental health-related issues such as suicide prevention, substance use in jails, and transgender healthcare in corrections.
- Aided in the development of a community care program for inmates to receive continued mental health services upon their release from jail.

Qualified Mental Health Professional
Racine County Jail

06/2016 – 08/2016
Racine, WI.

Pre-trial correctional facility and detention center

Supervisor: Melissa Caldwell Ph.D.

40 hours per week

- Counseled a caseload of 25-50 inmates on a variety of issues including but not limited to coping with incarceration, trauma, grief, substance abuse, emotion regulation, relationship issues, coping with serious mental illness, and career guidance.
- Assessed mental well-being, risk, and suicidality of detainees through individual therapy, brief crisis counseling, suicide-watch contacts, and restrictive housing rounds.
- Consulted with security regarding best placement of at-risk detainees to ensure safety of themselves and other detainees.
- Completed psychological intakes on newly admitted detainees to identify a mental health code and provide recommendations for their mental health needs while residing in the facility.
- Coordinated with medical team to determine best treatment for detainees.
- Collaborated with jail administration in developing new safety protocols for at risk detainees.

Doctoral Practicum Extern

08/2015 – 06/2016

MindStar Counseling, LLC.

Milwaukee, WI.

Outpatient mental health center serving clients ages 3-65

Supervisor: Starlette Patterson-Biddle, Ph.D.

15 - 20 hours per week

- Carried a caseload of 15-20 elementary-aged and adult clients from culturally diverse backgrounds.
- Performed intakes for adult and child clients for diagnostic and treatment recommendations.
- Presiding issues included, but were not limited to, anxiety, depression, obsessive compulsive disorder, trauma, oppositional defiance, management of psychotic symptoms, and career education.
- Facilitated a weekly empowerment therapy group for female adolescent sex-trafficking survivors that resided in the Grateful Girls Group Home.
- Conducted individual therapy in the community center, local daycare, and home of clients for elementary-aged children and their families.
- Assisted teachers of my elementary-aged clients with behavior management plans to utilize within their classrooms.
- Provided psychoeducation and behavior modification plans to parents and family members of elementary-aged clients.
- Delivered case updates during weekly individual and group supervision from a licensed psychologist.

Residential Counselor

06/2014 – 08/2015

Children's Home + Aid, Rice Child & Family Center

Evanston, IL.

Residential treatment center serving clients ages 6-14

Supervisor: Francois Jean-Paul, LCSW

40 hours per week

- Provided a consistent therapeutic environment for 10-15 children with emotional, learning, and/or behavioral disabilities.
- Assisted children in repairing or developing healthy relationships with family members by supervising family visits at the center and in the homes of client families.
- Provided behavior management and treatment interventions in accordance with the center's behavior management guidelines.
- Facilitated daily milieu therapy to promote the social, emotional, and intellectual growth of the clients.
- Implemented medical standing orders and distributed medications under training and direction of the nursing staff and on duty support staff.
- Participated as member of the treatment team in recommending treatment interventions for clients on the unit.
- Completed Medicaid compliant progress notes documenting therapeutic interventions and goal obtainment for children in the program.
- Acted as support staff for behavior management and crisis intervention in the classrooms at the onsite therapeutic day school.
- Trained in Crisis Prevention Intervention (CPI) to assist with safe de-escalation and management of disruptive and assaultive behaviors.

Masters Practicum Extern

08/2013 – 07/2014

Connections Day School

Libertyville, IL.

Therapeutic day school that serves students ages 8-21

Supervisor: Ruth Tompkins, Psy.D.

24 hours per week

- Counseled a caseload of 10 students over multiple concerns including but were not limited to depression, anger management, development of social skills, coping with loss, development of study skills, and relationship issues.
- Performed case management duties with outside psychiatrists, occupational and speech therapists, parents, and public-school personnel.
- Consulted with supervisor, principals, and teaching staff in regard to treatment needs for students.
- Attended client treatment meetings and assisted in recommending special education related services for the therapeutic school or public-school placements.
- Aided in creating social and emotional goals for Individualized Education Plans (IEP) for special education students.
- Utilized Animal Assisted Therapy by working with staff therapy dogs within the milieu and in individual therapy.
- Co-facilitated specialty groups such as drug and alcohol education, art therapy, and music therapy with licensed staff.

- Facilitated daily counseling group developing age appropriate social and emotional skills.

VOLUNTEER COUNSELING, CONSULTATION AND ADVOCACY EXPERIENCE

Film Committee Coordinator 12/2016 – 03/2017
American Women’s Psychology Conference Milwaukee, WI.

- Identified theme appropriate films pertaining to awareness of issues facing women of cultural identities.
- Contacted potential film resources to request appropriate films to display at the conference.
- Assisted with developing the schedule for film’s to be previewed throughout the conference.
- Staffed the film room during the duration of the conference while movies are screened and filtered questions about the films.

Project Management Intern 12/2013 – 05/2014
Mission Propelle Chicago, IL.

- Developed administration and data input protocols for pre- and post-test social and emotional growth surveys.
- Revised pre- and post-test surveys to administer to 1st-5th grade female students participating in the program.
- Analyzed pre- and post-test surveys administered to participants.
- Researched potential community partnerships within the Chicago Public School system and surrounding Chicagoland public and private school systems.
- Set classroom books to the Social and Emotional Learning Curriculum set by the Illinois school systems.

Foster Friend Mentor 06/2012 – 06 2014
Children’s Home + Aid Evanston, IL.

- Worked one-on-one with an adolescent girl that resided in a severe residential treatment facility mandated by the Illinois Department of Children and Family Services (DCFS).
- Planed educational and developmental activities for the adolescent girl that pertained to her interests such as arts and crafts and community activities outside of the center.
- Acted as a positive role model by teaching her valuable social and developmental skills.
- Assisted with goal setting and working towards achieving those goals such as saving money and improving her grades in school.
- Provided feedback to the program treatment team regarding her social skills in the community.

Classroom Mentor 06/2010 – 03/2011
Bellevue Therapeutic Day School Richmond, KY.

- Assisted at-risk male youth from Appalachian demographics in academics and life skills within a therapeutic day school setting.
- Developed educational and developmental activities for group therapy sessions for youth with behavioral and substance abuse issues.
- Acted as a co-leader during group therapy in discussing content such as drug and alcohol abuse, diversity issues, and bullying in schools.
- Tutored students in reading and mathematics within the classrooms.
- Administered drug screens to youth with a history of substance abuse and assisted in reporting their results to probation officers and/or the court system.

TEACHING EXPERIENCE

Adjunct Instructor 09/2017 – 12/2017
University of Wisconsin – Milwaukee Milwaukee, WI.

Course: Group Counseling Theory (COUNS 800) - 1 section per semester

Supervisor: Nadya Fouad, Ph.D. 10 hours per week

- Taught a three-credit graduate level course that supervised master's level students on the development and practice of their group counseling skills.
- Supervised students in the classroom setting as they practiced leading psychoeducational groups.
- Developed and presented weekly lectures on group counseling theories and skills.
- Observed and provided feedback for in class group activities and weekly homework assignments.

Co-Instructor 08/2016 – 05/2017
University of Wisconsin-Milwaukee Milwaukee, WI.

Course: Overview of Counseling Skills (COUNS 403) - 1 section

Supervisor: Nadya Fouad, Ph.D. 10 hours per week

- Taught a three-credit level course for advanced undergraduate providing an overview of counseling skills and theories.
- Developed curriculum for weekly lectures to Assisted in developing curriculum including quizzes and assignments.
- Facilitated class discussion and graded based on mastery of content and contributions to topics of interest.

Co-Instructor 08/2016 – 05/2017
University of Wisconsin-Milwaukee Milwaukee, WI.

Course: Certification Course for School Mental Health Professionals (COUNS 602) - 1 section

Supervisor: Nadya Fouad, Ph.D. 10 hours per week

- Taught a three-credit online graduate level course as an introduction to school mental health.

- Prepared weekly readings and discussion sections for students to discuss their questions and connections to the readings.
- Participated in weekly online discussions with students regarding weekly readings about school mental health issues.
- Evaluated student performance and provided support for student professional growth.

Co-Instructor

08/2015 – 05/2016

University of Wisconsin-Milwaukee

Milwaukee, WI.

Course: Successful Career Transitions (EDPSY 301) - 1 section

Supervisor: Nadya Fouad, Ph.D.

10 hours per week

- Taught a three credit online undergraduate level course on career readiness and transitional career skills.
- Graded and provided feedback for online discussions in order for students to develop better career transitional skills.
- Developed grading rubrics to ensure clarity of expectations.
- Provided feedback to students on weekly assignments and evaluated their final performance in the course.

Co-Instructor

08/2015 – 05/2016

University of Wisconsin-Milwaukee

Milwaukee, WI.

Course: Pathways to Success (EDPSY 104) - 3 sections

Supervisor: Nadya Fouad, Ph.D.

10 hours per week

- Taught a three-credit undergraduate course that assisted students in exploring careers, college majors, and developing professional skills such as interviewing and resumes writing.
- Assisted in developing curriculum for one section specific for veteran students and two sections specific for students on academic probation.
- Collaborated with other instructors and supervisor weekly to discuss classroom challenges, the upcoming week's curriculum, and other topics.
- Utilized career counseling style exercises to assist students in better understanding interests, values, and skills and their application to finding majors.

PRESENTATIONS

Weinhardt, L. S., Xie, H., Stevens, P., Wesp, L. M., John, S. A., Kioko, D., Chavez-Korell, S., Cochran, K. M., **Watjen, J. M.**, Labrou, N. H., & Muro, N. J. (2017, March). Role of family support in well-being among transgender and gender non-conforming youth. Poster presented at the American Public Health Association, Atlanta, GA.

Weinhardt, L. S., Xie, H., Stevens, P., Wesp, L. M., John, S. A., Kioko, D., Chavez-Korell, S., Cochran, K. M., **Watjen, J. M.**, Labrou, N. H., & Muro, N. J. (2017, March). Resilience, perceived stigma, social support, and self-esteem in transgender and gender non-conforming youth. Poster presented at the American Public Health Association, Atlanta, GA.

Chavez-Korell, S. C., Newell, M., Cochran, K., Pierson, H., **Watjen, J.**, Salas, S., Muro, N., & Callahan, K. (2017, August). Examining school related stress, mental health, and coping among high school students. Poster presented at the American Psychological Association, Washington, D.C.

Chavez-Korell, S. C., Newell, M., Muro, N., Zwolski, S., Tindall, C., Pierson, H., **Watjen, J.**, Salas, S., Ipecki, B., Mascari, L., Navarro, O., Brumm-Larson, J., Truscott, N., & Jennings, I. (2017, August). Break the relationship between poverty and associated risks: Role of coping and social support. Poster presented at the American Psychological Association, Washington, D.C.

Coventry, R. & **Watjen, J.** (2013). A safe community project: Community defense against the weapon of sex. Paper presented at Chicago Psychology Graduate Research Symposium, Chicago, IL.

Watjen, J. & Coventry, R. (2013). A safe community project: Re-defining risk, disclosure, and LGBT-friendly assessment. Paper presented at Engendering Change Conference, Chicago, IL.

Watjen, J. (2010). Transgender and transsexual students on college campuses. Paper presented at Eastern Kentucky University Honors Thesis Conference, Richmond, Kentucky.

PUBLICATIONS

Weinhardt, LS, Stevens, P, Xie, H., Wesp, L, Chavez-Korell, S, John, SA, Apchemengich, I, Kioko, D, Cochran, K, **Watjen, J.** Lambrou, N, (in press). Transgender and gender non-conforming youth's public facilities use and psychological well-being: A mixed method Study. *Transgender Health*.

Watjen, J. M., & Mitchell, R. (2012). College male's concerns about sharing dormitory space with a male-to-female transsexual. *Sexuality and Culture*. 14(1), 1-37.

RESEARCH PARTICIPATION

Psychology Research Assistant

07/2017 – 02/2017

University of Wisconsin – Milwaukee

Milwaukee, WI.

Principal Researchers: Lance Weinhardt, Ph.D. & Hui Xie, M.A.

Resilience, Perceived Stigma, & Self-Esteem in Transgender & Gender Non-Conforming Youth

- Recruited transgender and gender non-conforming youth to assess resilience factors, perceived stigma, social support, and self-esteem.
- Administered a quantitative questionnaire to transgender and gender non-conforming youth.
- Assisted with manuscript writing and presentation of data analysis for abstracts for public health conferences.

Psychology Research Assistant 09/2016 – 09/2017
University of Wisconsin – Milwaukee Milwaukee, WI.

Principal Researchers: Shannon Chavez-Korell, Ph.D. & Markeda Newell, Ph.D.

Nicolet High School Coping and Wellbeing Survey

- Recruited high school students enrolled at Nicolet High School to understand the relationship between school-related stress and mental health within schools.
- Administered questionnaire to students and assisted with questions throughout the duration of the survey completion.
- Completed data entry and assisted with data analysis using SPSS and SASS.
- Assisted with manuscript writing and presentation of data analysis results to school personnel.

Psychology Research Assistant 09/2016 – 09/2017
University of Wisconsin – Milwaukee Milwaukee, WI.

Principal Researchers: Shannon Chavez-Korell, Ph.D. & Markeda Newell, Ph.D.

Financial Stress and Resiliency

- Acted as a data collection coordinator to assist with onsite setup of data collection and consent process of participants.
- Assisted with recruitment events at local Boys and Girls Clubs across the Milwaukee area.
- Performed data collection using standardized measures to identify coping and resiliency factors for families experiencing financial stress.
- Attended biweekly research team meetings to discuss progress of the data collection and data analysis.
- Assisted with manuscript writing and preparing the poster presentation of data analysis results.

Psychology Research Assistant 05/2013 – 08/2015
Roosevelt University Chicago, IL.

Principal Researchers: Susan Torres-Harding, Ph.D.

Motivators and Experiences of Social Activists

- Assisted in designing a study that examined the experiences of social activist identity development within a university setting.
- Conducted the research by utilizing hour-long qualitative interviews with social activists in various universities around the Chicagoland area.
- Transcribed the interviews to use for qualitative coding.
- Analyzed the data through qualitative coding techniques to assess insight into the motivators and experiences of social activists.

Psychology Research Assistant 07/2010 – 06/2012
Roosevelt University Richmond, KY.

Principal Researchers: Robert Mitchell, Ph.D.

Men's Concerns with Male-to-Female Transsexuals

- Designed a research study that examined male students' attitudes towards sharing public spaces with male-to-female transsexuals.
- Developed a quantitative survey and scenarios that prompted qualitative feedback.
- Conducted the research study by uploading the survey and scenarios onto a university psychological survey database.
- Analyzed the data by assisting my colleague in statistical and quantitative and qualitative analysis.

ACADEMIC AFFILIATIONS

Newsletter Editor 09/2016 – 05/2017
Counseling Psychology Student Association (CPSA)
University of Wisconsin-Milwaukee Milwaukee, WI.
Faculty Advisor: Nadya Fouad Ph.D.

- CPSA is a student organization designed to advocate for the well-being of doctoral students in the Counseling Psychology program.
- Distributed a request for submissions on the doctoral student listserv and from department faculty.
- Composed original submissions for the newsletter on topics such as program highlights, student interviews, and internship and dissertation readiness.
- Created and distributed monthly newsletter utilizing written submissions from doctoral students and faculty.

PROFESSIONAL AFFILIATIONS

American Psychological Association of Graduate Students (APAGS) 2018 – Present
American Psychological Association (APA) 2016 – Present
American Counseling Association (ACA) 2016 – Present

AWARDS

Psychology Department Scholarship 2012 – 2014
 Roosevelt University

Grace Mary Stern Scholarship 2011 – 2012
 Roosevelt University

Portz Scholar Nominee 2011
 Eastern Kentucky University

Outstanding Psychology Senior Award 2010
 Eastern Kentucky University

Licensure & Certifications

Temporary Licensed Mental Health Counselor Indiana	08/2018 – Present
CPR Certified Indiana	06/2018 – Present
Licensed Professional Counselor – In-Training Wisconsin	03/2016 – Present