Introduction

“Sexuality counseling” is defined as counselling on issues related to one’s own sexual life experiences, problems, or concerns (e.g., avoiding unplanned pregnancies and sexually transmitted infections including HIV, sexual identity issues, unsatisfying sexual relationships, intimacy, and sexual violence) with the aim of creating a climate where clients can express themselves in a private and confidential environment and without fear of discrimination. (Khanna, 2008, p. 2)

Sexuality counseling focuses on providing psychotherapy for sexuality-related concerns which are psychological or emotional in nature. Over time, the field of sexuality counseling has shifted from a medicalized view to a “new view” focusing on idiosyncratic, relational, and sociocultural aspects of sexuality-related concerns (Southern & Cade, 2011). The focus has shifted from sex therapy to sexuality counseling which endeavors to apply a multicontextual perspective while managing issues of sexuality (Southern & Cade, 2011).

Individuals may face complexities due to sexuality-related issues which have a substantial influence on their lives, relationships, and their sense of worthiness. This fact was ascertained and triangulated by all the principal informants, as well as the focus group discussions (FGDs) and callers’ feedback taken during the course of the review of telecounseling services conducted by Talking About Reproductive and Sexual Health Issues (TARSHI) (Khanna, 2008). TARSHI, a New Delhi–based registered non-governmental organization (NGO), provides sexuality counseling services through a telephone helpline which is anonymous where individuals call in to discuss any sexuality concern (Khanna, 2008). The study demonstrated that the rapid commoditization of sexuality and sex due to the speedily
transforming markets, widespread propagation, and accessibility of the Internet and mass media has created a conflict between the traditional notions of sexuality and the market-centered, modern conceptualization of sexuality. Thus, on one hand, sexual violence and associated crimes have increased greatly, whereas, on the other hand, honor killings based on attempts to preserve traditional values are still rampant. The circulation of contradictory messages by the media which propagate “sex for pleasure” at one end while talking about “sex only within marriage” and “sex for producing progeny” at the other end further compound the problem by creating confusion (Khanna, 2008). This confusion is exacerbated by differing standards for men and women (Khanna, 2008). All these factors highlight the pressing need for widespread counseling services focusing on sexuality-related issues.

The knowledge of sexuality and related issues may play an important role in the efficacy of sexuality counseling offered by a counselor. A research conducted by Kazukauskas and Lam (2009) with certified rehabilitation counselors found that knowledge of sexuality and attitude toward sexuality are positively linked with the comfort in engaging with issues of sexuality with clients. In the context of diverse sexual practices and sexual orientation, there is very limited that is offered by psychology programs across the world in terms of training or reading material. For instance, it has been found that most psychology undergraduate and graduate programs do not provide a lot of education on lesbian, gay, bisexual, and transgender (LGBT) and barely involve even a mention of polyamorous and BDSM (bondage and discipline, dominance and submission, sadism and masochism) subcultures in the syllabus, text books, and internship trainings (S. Miller & Byers, 2009; Weitzman, 2006). In the United States, one can become a certified sex therapist and receive accreditation by the American Association of Sexuality Educators, Counselors and Therapists (AASECT).

At present, there is no formalized comprehensive sexuality training curriculum or training for counselors and therapists in India. The counselor training programs at the graduation and postgraduation levels in India often do not have a component on sexuality other than a section on sexual dysfunctions within psychopathology and abnormal psychology courses. NGOs in different parts of the country, working on different issues, often conduct trainings focusing on the specific sexuality-related issues that is of concern to them, for instance, concerns of men who have sex with men. Furthermore, certificate courses on sexuality are offered by various NGOs and private organizations. For instance, TARSHI, Delhi, offers a certificate program in sexuality for counselors. A private organization called “Heart to Heart Foundation” offers a certificate course for training sex educators in Mumbai.

Given the paucity of structured training programs which equip counselors to provide psychotherapy for issues of sexuality, particularly in the Indian context, other factors including counselors’ own comfort with issues of sexuality may play an important role in the interventions undertaken by them with regard to issues of sexuality.

“Sexual comfort” with regard to welfare professionals may be defined as, proposed by Graham and Smith (1984), the ability to (a) openly discuss sexual feelings and attitudes with clients, (b) respect and accept client sexual practices, and (c) communicate effectively about sexuality. Comfort has found to be significantly associated with the willingness to discuss sexuality issues. Past research suggests that counselors are often not comfortable in engaging with issues of sexuality. For instance, a research study conducted with marriage therapists to determine the degree to which they encouraged the discussion of sexual issues in therapy found that therapists often did not inquire in detail about the sexual life of the couple (Heitler, 2012). This lack of engagement with issues of sexuality was postulated to be associated with embarrassment along with other factors such as lack of knowledge, training, and focus on the more covert issues (Heitler, 2012). Research has also shown that clients’ needs for receiving counseling pertaining to issues of sexuality are often not met in rehabilitation and health care settings due to the discomfort of professionals with counseling situations which include sexuality (Yallop & Fitzgerald, 1997).

Comfort may have a significant bearing on the counseling interventions provided by counselors. Feeling uncomfortable may significantly hinder the therapeutic relationship as well as outcomes because it may, for instance, be associated with being nervous and embarrassed (Kirkpatrick, 1994), while feelings of unease and disquiet have also seen to be associated with feeling uncomfortable (Pollard & Liebeck, 1994). It is highly plausible that professionals who experience discomfort in engaging with the sexual health needs of their clients may fail to educate their clients on issues of sexuality and discuss their sexual concerns in a detailed manner. Research in the context of marriage and family therapy has suggested that it is important for marriage and family therapists to be adequately comfortable with the queer populations so as to be able to build warm and supportive therapeutic relationships with them (Bernstein, 2000).

Being uncomfortable with a client’s concern may hinder the therapist from engaging in ethical practice. The hallmark of ethical practice involves a consideration for the ethical principles of beneficence, nonmaleficence, autonomy, justice, and fidelity (Corey, 1996). These principles imply engaging in the counseling relationship with the client’s well-being and needs being the primary goal, avoiding causing any harm to the client, encouraging independent decision making by the client, providing a just and equal treatment to all the clients irrespective of their identity, and being honest with the client about the course and progression of therapy. Working with clients whose counselors are not comfortable may be a violation of the ethical principles of beneficence and nonmaleficence which focus on ensuring the well-being of the clients.
In 1976, at an Ethics Congress in the United States which aimed to formulate ethical guidelines for working with issues of sexuality in psychotherapy, H. Tristram Engelhardt Jr. outlined the following four basic principles to ensure ethical practice and prevent exploitation when engaging with issues of sexuality. (a) Therapists and counselors must avoid the use of disease language so as to prevent the stigmatization of individuals or unintentionally imposing one’s own cultural values on them. (b) Counselors should exercise caution to avoid condemning diverse sexual practices as immoral, other than circumstances in which they may be perceived as coercive. Therapists must inform clients about their moral stance with regard to diverse sexual practices before the initiation of therapy. (c) Therapists must not disguise therapeutic arguments for or against a particular sexual lifestyle as proven facts or as moral givens. (d) Counselors should exercise special care to not become sexually involved with clients (Kolodny, 1978). Furthermore, in this conference, another core principle was identified as being the awareness of personal values and biases that may be introduced in the therapeutic context or may deeply influence the counseling process (Kolodny, 1978).

The AASECT is the primary source of guidelines associated with quality as well as ethical sexuality counseling. According to the AASECT, all services should be within the limits as well as the area of the practitioner’s competence with the limitations being communicated beforehand to the clients (“Code of Ethics & Conduct for AASECT Certified Members,” 2014). All services should be in keeping with the professional standards of the profession and they should involve the willingness as well as the ability to refer the client to an appropriate service provider when the services go beyond the practitioner’s current level of expertise (“Code of Ethics & Conduct for AASECT Certified Members,” 2014).

Previous literature has examined the psychotherapeutic interventions undertaken with different populations and a myriad range of sexuality concerns. Thus, for instance, a study undertaken by Love-Crowell and Lawrence in 2008 found that according to psychotherapists who had extensive experience in working with clients who engage in BDSM practices, competent and ethical practice in this area is inclusive of sufficient knowledge, nonjudgmental acceptance, cultural competence, and the ability to refrain from pathologizing these practices. With regard to working with clients who are nonheteronormative, research has emphasized the importance of being able to be an “ally” for the client, which implies offering support and services to lesbian, gay, and bisexual (LGB) individuals themselves as well as attempting to build the awareness and sensitivity of heterosexual persons and institutions (Washington & Evans, 1991). According to Israel and Selvidge (2003), a very important aspect of competent practice with nonheteronormative populations is the ability to be cognizant of between- and within-group differences with regard to these groups.

Competent practice with regard to sexuality-related issues may be seen as commitment to confidentiality, evidence-based information provision, and rights-based and gender-sensitive practice (Khanna, 2008). It may also be seen as being associated with outcomes such as demystification of sexuality, increased awareness and comfort with one’s own body, reduction in shame and stigma, positive sexual health, safer sexual behaviors, and attitudinal change with regard to issues of sexuality (Khanna, 2008).

**Rationale for the Study**

While being an intrinsic part of our lives which holds idiosyncratic meaning for each one of us, sexuality has been associated with taboo and shame. The strict social regulation on human sexuality may make even slight departures from normative sexual expression and practice seem as aberrations which may invite severe social consequences in the form of discrimination, ridicule, alienation, and subordination.

The fear of such severe social consequences forces individuals to lead closeted lives which further results in psychological problems resulting from living a dual life, inauthentic relationships, restrictive choices, and so on. In the face of such limiting life circumstances and the resulting feelings of dissatisfaction, clients may seek recourse to counseling. Clients may approach counselors for specific sexual problems which cause a lot of distress while at other times sexuality factors may remain hidden behind the more obvious problems presented by the client. In all these cases, the counselors’ own comfort with these concerns and his or her capability to provide a safe, respectful, and empathic environment to the clients in which they can share their concerns openly and feel encouraged to explore their sexuality play a vital role in successful counseling practice. Thus, it is vital to examine the counselors’ own comfort and interventions with regard to these concerns.

**Method**

With the twin objectives of examining Indian counselors’ comfort with issues of sexuality emerging in counseling practice and exploring the interventions commonly employed by them upon encountering the same, the present study was conducted as a part of a postgraduate dissertation. An exploratory mixed-method research design was used and data were collected in 2014 from 31 counselors residing in the Delhi region of India. The inclusion criteria used for the study was the attainment of a postgraduate degree in Psychology and at least 1 year of experience as a practitioner. Setting of practice and client population were not used as inclusion criteria so as to emphasize that sexuality is intrinsic to counseling endeavors in every setting. Furthermore, counselors working specifically on issues of sexuality were not solely chosen for the study due to the dearth of such counselors in the Indian context. Purposive and snowball sampling techniques were used
for sample recruitment due to limited number of counselors practicing in the Delhi region. These techniques were also used for sampling because counselors constitute a hidden population in India due to lack of organized bodies and directories enumerating and listing out all the counselors in the country or the city. As a result of the usage of these sampling techniques, the generalizability of the study is limited. However, generalizability was not the aim of the study due to its exploratory nature.

A self-constructed questionnaire was used for the purpose of data collection which was administered to the participants for self-completion. The questionnaire consisted of a number of open-ended and closed-ended questions. The content validity of the questionnaire was assessed by reviewing pre-existing literature and tools, and through consultation with two experts from the field. A pilot study was conducted with 11 trainee counselors pursuing their postgraduation in General, Clinical, and Counseling Psychology in educational institutions in Delhi and Mumbai. The pilot study was not conducted on practicing counselors, so not to exhaust the sample for the final study given the limited number of practicing counselors available and accessible for research in Delhi. The feedback of the participants of the pilot study was taken and the time taken by the participants to complete the entire questionnaire was noted.

The questionnaire used for data collection consisted of the following sections:

**Sociodemographic Sheet**

The sociodemographic sheet consisted of 11 items including the participant’s educational qualifications, theoretical orientation, years of experience as a practicing counselor, number of clients seen per week, client profile, and so on.

**Case Vignettes**

In all, 10 case scenarios were constructed which consisted of a range of sexuality-related scenarios which could be presented in counseling. These case vignettes were brief. The counselors had to list three interventions they would undertake in each of the scenarios.

**Comfort Scale**

The case vignettes were followed by a 5-point Likert-type scale (where 1 represented “totally uncomfortable” and 5 represented “totally comfortable”) wherein the counselors were required to indicate their level of comfort in dealing with each case scenario. Post hoc interitem consistency was measured for the comfort scale using Cronbach’s alpha. The Cronbach’s alpha value was found to be .772, indicating that the scale possesses inter-item consistency.

Most of the data collection sessions took approximately an hour. Sometimes data collection had to spread over multiple visits due to prior time commitments of the counselors. Every data collection interview consisted of a debriefing session which was conducted after the participant had completed the questionnaire. These debriefing sessions were aimed at explaining the objectives of the study in greater detail as compared with the explanations provided at the beginning, clarifying any queries that the participants may have, recording their experiences of filling the questionnaire, obtaining their feedback on the study, and reassuring them about the dissemination of results after the completion of the study. At the end of each data collection interview, the participants were thanked for being a part of the study and were also given a few resources on sexuality, that is, a list of reading material on sexuality and its subdomains as well as a list of NGOs which worked on sexuality-related issues in Delhi which they could refer their clients to.

While the data collection process was an enriching process for the researcher, a few challenges were faced. Finding participants for the study was a significant challenge for the researcher as the universe of study was a very limited and elusive one as well as due to the time of the year at which the data were collected. Furthermore, due to the topic being studied, some counselors were hesitant to be a part of the study. Another difficulty was associated with the vast territory of Delhi due to which the researcher often had to travel to distant corners of the region as the counselors were spread across the region. Another challenge during data collection was to ensure that all the questions were answered by the counselors. The final challenge included ensuring standardized responses to clarifications asked by the counselors while filling the questionnaire so as to ensure that information that could influence responding was not divulged and the counselors were allowed to entirely use their own discretion while responding.

To analyze counselors’ comfort levels in engaging with issues of sexuality, composite scores were calculated by summing up participants responses to each of the 10 items on the comfort scale, and the mean, standard deviation, and range were obtained. The open-ended questions aimed at eliciting counselors’ interventions with issues of sexuality were analyzed using thematic analysis.

The process of data collection was undertaken keeping in mind the ethical consideration. Informed consent for participation in the study was obtained by the counselors by the way of a cover letter which obtained their consent as well as ensuring voluntary participation by the counselors in the study. The anonymity and confidentiality of participants were ensured while reporting the results.

**Results**

**Profile of Participants**

The counselors sampled for the purpose of the study were very diverse in terms of their age range, educational
qualifications, years of experience, theoretical orientations, and setting of practice. Most of the counselors in the sample were women (90.32%), and they ranged from 23 to 70 years of age.

While obtaining a postgraduate degree in psychology was an inclusion criteria for the sample, one of the participants included in the sample did not have a master’s degree in Psychology. However, the knowledge that the counselor did not fit the inclusion criteria was attained after collecting data. The data provided by the participant was very rich in content. Thus, due to the small sample size and richness of data, the participant was included in the sample of study.

The sample was very diverse with regard to the educational qualifications with some professionals varying widely in terms of the number and kinds of degrees they had pursued and obtained. Almost half of the participants (45.14%) possessed only a master’s degree but these degrees were obtained in varied branches of psychology. Nearly a quarter of the participants (22.58%) had completed their MPhil, while an equivalent number (22.58%) had completed or were pursuing their PhD.

The settings of practice were quite disparate as well with half of the participants (51.61%) working as private practitioners, some participants (38.71%) working in schools and university setups, a quarter of the participants (25.81%) working in clinics and hospital setups, and a small proportion (9.68%) of the participants working in NGOs or other agencies on a part-time basis. It was seen that most counselors tended to practice in multiple setups.

The profile of the clients seen by the participants varied tremendously. Two main categories used by counselors to describe the profile of their clients were age and the issues that were presented in counseling. Some of the participants worked with children and adolescents as well as their parents whereas others tended to see young, middle aged, and older adults. However, there were some counselors who worked with children as well as adults. With regard to issues seen, some counselors worked only with clinical populations. The client profile also depended greatly on the setting of practice. Thus, for instance, someone who worked in a school was likely to see only children and their families while someone who worked in a hospital setting was more likely to work only with clinical problems and mental illnesses. This may influence their comfort in work with specific issues. For instance, those in a hospital may have worked with sexual dysfunctions while those working in a school would be more likely to be exposed to issues of teenage sexuality.

The counselors differed from each other in terms of their theoretical orientation with some of them claiming to have a clear allegiance to a particular school of thought such as psychoanalysis or cognitive behavioral therapy (CBT). However, most counselors claimed to use a blend of various schools of thought depending upon the client’s specific needs and issues and a few of them also called themselves “eclectic.”

Counselors’ Comfort With Issues of Sexuality

Participants’ comfort levels with case scenarios depicting different issues of sexuality. A frequency analysis of the responses provided by the participants on the comfort scale was conducted by combining the ratings of “totally uncomfortable” and “uncomfortable” as well as the ratings of “comfortable” and “totally comfortable.” Table 1 depicts the percentage of participants who felt uncomfortable or comfortable in each of the case scenarios as well as the percentage of participants who were “neither uncomfortable nor comfortable.”

Counselors reported high levels of comfort in most of the situations. There were a few case scenarios in which the counselors reported being more comfortable as compared with other. For instance, all the counselors reported being comfortable in dealing with the concerns of a parent who is upset about his 10-year-old daughter being given sex education at school. This high level of comfort has been reported by counselors irrespective of the client populations seen by the counselors, that is, irrespective of whether they work with children or adults or other populations.

An overwhelming majority of counselors reported being at ease in counseling a woman with sexual harassment concerns (96.77%). A considerable majority of counselors (90.32%) have reported being comfortable when faced with a gay or lesbian client whose parents are forcing him or her to marry a person of the opposite gender.

There were some case scenarios that were reported to be comfortable by a relatively fewer proportion of counselors. For instance, only 48.39% counselors reported being comfortable upon being encountering a couple that wants to engage in BDSM activities. Another scenario that was comfortable for a relatively fewer proportion of the sample (67.74%) was being faced with a HIV-positive client who does not wish to reveal his positive status to his fiancé.

Overall comfort levels of the participants. The mean for the comfort scale designed to assess counselors’ comfort levels in engaging with sexuality issues was found to be 41.806 while the standard deviation was computed to be 6.063. The expected range for the entire questionnaire was 10 to 50 due to the presence of 10 items in the questionnaire which had to be rated on a 5-point Likert-type scale. The lowest score obtained by a counselor was 29 while the highest score was 50, thereby leading to the range being equal to 21 (Table 2). The mean that could have been possibly obtained by the entire sample was 30; however, the mean that was obtained in actuality was greater than that, that is, 41.806 > 30, by more than 10 points, and thus, it can be claimed that the counselors are fairly comfortable in dealing with issues of sexuality.

Counselors’ Interventions With Issues of Sexuality

Counselors listed a range of interventions upon being asked to list three interventions for each case scenario.
The responses provided by the counselors provided an insight into the manner in which the counselor would approach the cases including the stance of the counselor, the processes, and interventions that would be undertaken by the counselor as well as the legal and ethical considerations that would be kept in mind by them. These three thematic categories have been explored in this section.

### Table 1. Frequency Analysis of Counselors’ Reported Level of Comfort With Regard to the 10 Case Scenarios (n = 31).

| S. No. | Case scenario                                                                 | Uncomfortable (%) | Neither uncomfortable nor comfortable (%) | Comfortable (%) |
|--------|-------------------------------------------------------------------------------|-------------------|-------------------------------------------|-----------------|
| 1.     | A 15-year-old pregnant girl who hasn’t told her parents comes to you for help because she doesn’t know what to do. | 16.13             | 9.68                                      | 74.19           |
| 2.     | A gay or lesbian individual comes to you as he or she doesn’t know what to do because his or her parents have been forcing him or her to marry an individual of the opposite sex and lead a “normal” life. | 6.45              | 3.23                                      | 90.32           |
| 3.     | A 24-year-old man diagnosed as HIV-positive and wants to keep his HIV status hidden from his fiancé comes to you for counseling. | 19.35             | 12.90                                     | 67.74           |
| 4.     | A high school student thinks he is a female trapped in a male body and has tried to express this to his parents but they refuse to take him seriously. He comes to you for counseling | 9.68              | 12.90                                     | 77.42           |
| 5.     | A mother comes to you with her 18-year-old intellectually disabled daughter who she has caught touching her private parts on multiple occasions and sometimes even in the presence of others. She doesn’t know how to handle the situation and wants your help. | 9.68              | 9.68                                      | 80.65           |
| 6.     | A 68-year-old couple comes to you as they want to rekindle their romance and are looking for new ways to develop intimacy. | 16.13             | 6.45                                      | 77.42           |
| 7.     | A 13-year-old boy, who wants to experiment sexually, comes seeking advice on contraception and diverse sexual practices. | 6.45              | 9.68                                      | 83.87           |
| 8.     | A couple wants to try sadomasochistic sex as they have heard and read a lot about it. They come to you seeking knowledge about how safe it is. | 29.03             | 22.58                                     | 48.39           |
| 9.     | A 30-year-old woman has been facing sexual harassment at work since the past 1 year and cannot avoid it any longer as it has started affecting her work. She comes to you for help. | 3.23              | 0                                         | 96.77           |
| 10.    | A parent finds out that his 10-year-old daughter is being taught about sex and safe sex practices in her class. He is absolutely furious and is sent to you by the school authorities to explain about the importance of sexuality education. | 0                 | 0                                         | 100             |

### Table 2. Mean, Standard Deviation, Expected Range, and Obtained Range for the Comfort Level in Engaging With Issues of Sexuality (n = 31).

| Domain                                      | M     | SD    | Expected range | Obtained range |
|---------------------------------------------|-------|-------|----------------|----------------|
| Comfort level in engaging with sexuality     | 41.806| 6.063 | 10-50          | 29-50 (=21)    |

The approach. The responses of the counselors often were helpful in understanding the underlying beliefs of the counselor which would guide the counselors’ approach. While some responses were reflective of a lens which pathologized and medicalized the client’s sexuality concerns, other responses validated, normalized, and even affirmed the client’s dilemmas about their own sexuality. The responses also differed in terms of the degree to which the counselor wished to be collaborative and reduce the power hierarchy within the session. The responses which were collaborative and facilitatory in nature were markedly different from those which were directive and expert-driven in nature. These aspects have been elaborated upon in the following subthemes.

1. Pathologizing the client versus affirming the client: Some of the interventions written by the counselors
were reflective of a stance which focused on assessing the client, diagnosing the client, and seeking psychiatric interventions for the client. For instance, upon being presented with the case of the teenager who reported feeling like a female in a male’s body, one of the counselors (female, 31) wrote “psychiatric medication” among the intervention strategies she would employ. Furthermore, the counselors also mentioned employing projective tests such as the Rorschach Inkblot Test and the Thematic Apperception Test (TAT) to ascertain if the client had hidden any information. These responses indicate that some of the counselors may be very bio-medical in their stance and may “pathologize” the sexuality concerns of the client due to their belief in diagnosis. Furthermore, the values held by counselors against some sexual practices presented in the case scenarios were also elicited. This was particularly evident for the case scenario involving BDSM. A 46-year-old female counselor, while listing interventions for this case scenario, wrote, “Tell them this is unnatural.” However, some of the responses provided by the counselors were very affirmative in nature. In these responses, the counselors employed strategies focusing upon normalizing the sexual curiosity of their clients, validating their concerns, and destigmatizing their varied gender identities and sexual orientations thereby enabling the clients to build comfort in their own sexuality. The following intervention strategy listed by a 30-year-old female counselor in response to the case scenario involving a 13-year-old boy who desires to engage in sexual experimentation is illustrative of such an affirming response, “Validate that it is okay to be curious at this age.” Another instance of an affirmative response is the following response provided by a 35-year-old female counselor in response to the case scenario which presented a 68-year-old couple who had come for counseling with the objective of rekindling their romance: “I would tell the couple that it is normal to have these feelings.”

2. Being directive versus being collaborative: Some counselors displayed a directive, “expert driven” approach while some were collaborative and facilitatory in their approach. This difference in the counselors’ approach to psychotherapy was noticeable through the language used by the counselors while describing interventions and the strategies suggested by counselors. Counselors who were directive often mentioned “telling” the clients about the course of action, bringing other parties to the counseling setting without the consent of the client. Such responses often excluded the possibility of engaging in a dialogue about the courses of action that the client could take and often positioned the counselor as a “teacher” of the client. For instance, when presented with the case scenario of a 30-year-old woman facing sexual harassment, one of the counselors (female, 48) wrote, “To teach her to be assertive. To teach her to put forward her complaint to the authority concerned.”

3. Counselors who were nondirective and facilitatory in their approach reported leaving the decision to the client upon exploring various options with the client and preparing them for consequences of various actions. While they encouraged familial involvement, they valued the consent of the client and mentioned strategies such as encouraging the client to involve family members and preparing the client for conversations with family members. Even in cases where a breach of confidentiality was considered necessary by them, they wrote about informing the client before inviting other family members for counseling. These counselors emphasized valuing the client’s right to make his or her own choices. This is illustrated by the following intervention written by a counselor in response to a scenario wherein a client experiencing sexual harassment at work seeks therapy, Encourage and support her through the situation if she is willing to take it up legally or with the police, help her to do so, after making her aware of some of the publicity/negative reactions that may arise, and helping her to make a choice of taking action against the harassment or looking for work elsewhere. It will be her decision. (70, Female)

The process and interventions. While the counselors enumerated the interventions that they would undertake for each of the case scenarios, they also wrote about the processes that they would undertake within psychotherapy to establish the therapeutic relationship. This thematic category encapsulates the multitude of interventions listed by the counselors and the processes that were mentioned by them.

1. Building the therapeutic relationship: Counselors often wrote about important processes aimed at establishing the therapeutic relationship. The counselors mentioned making the client feel comfortable through the use of empathy, calming the client, building a trusting relationship, providing a nonjudgmental safe space to voice out distress, active listening to make the client feel “heard,” and so on.

2. Interventions for emotional distress: The counselors aimed at working toward reduction of emotional distress experienced by the clients through the interventions enumerated by them. They wrote that they would focus on alleviating the inhibitions, insecurity, apprehensions, and fears of clients. Counselors articulated the necessity of directing therapy toward the goal of countering the host of negative emotions that may be experienced by clients including their guilt,
shame, anger, and so on. For example, upon being presented with the scenario of a high school student who thinks that he is female trapped in a male body, a 36-year-old female counselor wrote that she would endeavor to “lower shame and guilt.”

3. Interventions for challenging cognitions: Cognitive behavioral intervention strategies with the aim of resolving the problem and helping the client come to a decision such as problem solving, evaluation of the consequences of a particular decision, training in problem solving were frequently mentioned. An example of a CBT intervention is the following response written by a 37-year-old male counselor in response to the case scenario of a 24-year-old HIV-positive man who does not wish to reveal his HIV status to his fiancé: “Helping the client see pros and cons of deciding to do whatever he decides to do.” Counselors reported being interested in exploring the belief system of the client to deconstruct a scenario/problem. For instance, a 36-year-old female counselor wrote the following intervention in response to the case scenario involving a gay/lesbian individual being forced to marry an individual of the opposite sex and lead a “normal” life: “Explore belief of ‘letting family down.'”

4. Behavioral interventions: Behavioral strategies such as assertiveness training, communication skills, parenting skills, behavior modification, and so on were often listed by counselors. For instance, when faced with the scenario of the 68-year-old couple that wishes to rekindle their romance, counselors wrote that she would work toward teaching them how to communicate effectively with each other about their needs. Behavioral techniques were listed for various case scenarios such as ritual prescription for the 68-year-old couple, making a contract with regard to what was acceptable versus what was not acceptable for the scenario involving the couple that was seeking therapy for experimenting with BDSM activities, distraction techniques aimed at reorienting the 13-year-old boy (who was shown as wanting to experiment sexually by engaging in BDSM practices). The intervention strategies included provision of reading material for increasing the couple's knowledge about BDSM practices with the objective of enabling them to make an informed decision.

6. Building social support: Counselors suggested interventions aimed at enhancing the social support of the client by linking them with support groups; enabling them to reach out to supportive family members, peers, and friends; connecting them with community resources; working toward sensitizing their colleagues; suggesting group therapy and so on. These interventions were often written in response to scenarios when the family support was limited, the client was experiencing trauma and exploitation, and/or the client was a minor. For instance, when presented with the situation of the high school teenager who felt like he is a female trapped in a male body, one of the counselors (female, 31) said if the client would be unable to integrate different parts of himself or herself, “Then support group. Identify people who can provide support.”

7. Interventions with couple and/or family: While some case scenarios involved couple or a mother–child dyad and necessitated a family or couple intervention strategy, there were numerous scenarios which involved just individuals, and yet in such situations, a lot of counselors suggested involving the family or the parents. This was particularly true for case scenarios involving minors. A few of the family intervention strategies suggested by counselors included psychoeducating the parents (the content of Psychoeducation varied depending on the specifics of the situation), conducting conjoint sessions with the client and his parents so as to facilitate communication between them about the relevant issue, exploring the familial beliefs, counseling parents to accept their child’s sexuality, helping parents deal with their “perceived loss,” and so on. For instance, when presented with the scenario where a father who finds out that his 10-year-old daughter is being taught about safe sex practices at school is sent to the counselor so that he or she can tell him about the importance of sex education, one of the counselors (female, 31) wrote, “Suggest couple therapy to bring wife into equation as this is a parenting issue.” Therapists often conceptualized the issues in systemic terms and thought that involving the parents or the partner would be conducive in increasing the efficacy of the intervention.

8. Frequently mentioned psychotherapeutic models: The therapies often mentioned by the counselors while listing interventions involved family therapy, sex therapy, couple therapy, supportive counseling, CBT, assertiveness training, insight-oriented work,
behavior modification, and so on. It is noteworthy that often the counselors just named these schools of therapies in the intervention section without an elaboration of the specific strategy or intervention that they would use.

**Legal and ethical considerations.** Counselors made a consideration for the laws of the country which were pertinent to the client’s concerns. This was evident through intervention strategies which involved providing relevant legal information to the client or seeking a legal consult for the individual. For instance, in the scenario involving the 30-year-old woman experiencing harassment at work, a suggested intervention was provision of information about laws against sexual harassment and referral of the client to a legal expert. This approach illustrates the willingness to engage with the country’s legal system and not just limit one’s intervention to psychological and intrapsychic aspects.

Some of the scenarios presented ethical dilemma concerning client’s right to autonomy and confidentiality. For instance, the scenario involving the client who is HIV-positive presented the dilemma of the client’s right to autonomy and privacy versus the client’s fiancé right to safety. The case scenarios focusing on minors involved the consideration that their parents were their legal guardians. This was particularly relevant in situations wherein the counselors perceived the minors to be in foreseeable harm. In these scenarios, the counselors were able to identify the ethical dilemmas involved but differed in the resolution of these dilemmas. Some counselors wrote about encouraging the client to inform the other party themselves while preparing the client for disclosure and for the anticipated responses. However, some counselors suggested commanding the client to tell their parents/partners or mentioned telling the parents/partners themselves and conducting a joint session with them and the client(s) without seeking the clients’ consent or considering their comfort with the same.

**Counselor’s Comfort With a Case Scenario and the Decision to Refer the Client**

In situations in which the counselors reported discomfort or indecision about whether they were comfortable or not, they often wrote that they would refer the client to a colleague who, in their opinion, was an expert in managing the respective concern. This can be illustrated through the following intervention written by a 30-year-old female counselor in response to the case scenario of a 13-year-old boy seeking advice about experimentation and contraception; the counselor had provided a comfort rating of “three” (equivalent to neither being comfortable nor uncomfortable in the situation) to this case scenario: “Refer to colleagues. I’ll be comfortable exploring such concerns with adults not with minors.” This response shows the counselor’s understanding of the limits of her competence as a counselor and her prioritization of the well-being of the client.

However, there were situations where the counselors reported being uncomfortable but did not report seeking a referral or supervision. They gave responses which suggested that they would continue working with the client despite their own discomfort. A few counselors reported feeling completely uncomfortable in a few situations and they did not list any intervention for the respective scenarios. Such responses reflect a lack of awareness of alternatives such as seeking supervision, referring the client to another professional for concerns that fall outside the area of expertise of the counselor. However, such responses may have resulted from the way in which the question was worded, whereby it may have seemed to the counselors that they have to mandatorily list three interventions for each situation. Furthermore, counselors may not view “referral” or “consultation/supervision” or “checking for own biases” as intervention strategies which could be listed in response to the question. These responses may also stem from the realities of counseling and psychotherapy in the country wherein due to the dearth of counselors, professionals may be forced to continue providing psychotherapy to clients despite of feeling ill-equipped to do so.

There were some case scenarios in which the counselors reported being “somewhat comfortable” or “totally comfortable” and even then reported referring the case to another therapist who was more knowledgeable. This shows a counselor may feel comfortable but not sufficiently equipped or trained as a professional to intervene in various counseling situations. This strategy of referring the clients even upon being comfortable with the case scenario is reflective of ethical practice as the counselors seem to be able to prioritize the client’s beneficence and ensure that the client’s well-being is not jeopardized due to their lack of training/knowledge.

Oftentimes, counselors reported referring the case to a sexologist or a “sex counselor.” Such responses may be reflective of their notion that issues of sexuality do not fall within the realm of a regular psychotherapist/counselor. This notion reflects a belief in the separation of the sexual from the psychological which suggests a simplified conceptualization of client issues which are often not clearly stratified and involve social, psychological, sexual, biological, and relational elements. Furthermore, this notion is very misrepresentative of the realities of the Indian context where due to the paucity of mental health professionals, social workers, as well as sexologists, often there is no clear delineation of roles/expertise.

**Discussion**

Counselors perceived themselves as being fairly comfortable with regard to varied sexuality issues. This comfort may be a result of a variety of factors as indicated by previous research. For instance, this perceived comfort may be a
result of their exposure to sexuality-related issues due to their knowledge about these issues (Harris & Hays, 2008), their experience as a counselor (Cupit, 2010), their positive attitudes toward sexuality (Anderson, 2002, as cited in Cupit, 2010, p. 2), and so on. These factors were not studied in the present study, and thus the role of these variables can only be speculated upon, but cannot be commented upon, conclusively. However, social desirability bias could have played an important role in the responses provided by the counselors and cannot be ignored. Furthermore, high perceived levels of comfort cannot be mistaken to be a dependable indicator of their actual degree of comfort while engaging with issues of sexuality in their practice.

Most of the interventions listed by the counselors for various case scenarios were evidence-based interventions. Previous research studies have provided evidence for the efficacy and effectiveness of these interventions. For instance, numerous CBT interventions were listed by counselors who wished to focus on challenging and restructuring the beliefs of the clients. Research studies have examined the effectiveness of CBT interventions while working with sexuality issues with clients, and promising results have been found for CBT interventions with sexual disorders (Frühau, Gerger, Schmidt, Munder, & Barth, 2013), survivors of sexual abuse (Macdonald, Higgins, & Ramchandani, 2007), and so on. Psychoeducation or information provision, an intervention technique that was frequently mentioned by the counselors, has been proven to be an efficacious intervention strategy by previous studies—for instance, a study conducted by Yanaga, Ono, and Shirahata (1996) with HIV-positive hemophiliacs, their family members, and their sexual partners in Japan. Strategies for building social support were written by counselors to enhance the client’s support networks. Research studies have shown the efficacy of connecting clients to supportive networks and building supportive relationships as interventions (Dietz & Dettlaff, 2008).

Counselors were found to be affirmative in their approach to counseling. Affirmative approach toward working with sexuality issues has been found to be helpful by clients undergoing therapy due to the values of empathy, affirmation, safety, and nonjudgmental acceptance which are intrinsic to these strategies (King, Semlyen, Killaspy, Nazareth, & Osborn, 2007). The affirmative approach to sexuality affirms sexuality as being fundamental to the lives of people and makes demands for the recognition of sexual rights within the framework of basic human rights. This commitment to rights may be reflected in the commitment to the ethical principles of bodily integrity, equality, personhood, and respect for diversity (Corrêa & Petchesky, 1994; A. Miller, 2000). An affirmative framework employs the principle of consent or “free and fair choice” as a parameter to determine acceptable sexual behavior and acknowledges the different meanings that people bring to different sexual acts (Rubin, 1999).

The intervention strategies listed by the counselors in the present study can be conceptualized along the affirmative sexuality framework (TARSHI, 2000) with a commitment to ethical principles of personhood, equality, bodily integrity, respect for diversity, and consent, as well as the inclusion of pleasure and affirmation being used as the parameters for judging the responses of the participants.

The participants’ responses indicated the influence of counselor variables including their theoretical orientation, experience of working with specific client populations, their own attitudes, and beliefs in the interventions undertaken by them. This is consistent with previous literature which has repeatedly emphasized and portrayed counseling to be a personal enterprise which is deeply influenced by person of the counselor (Gibson & Mitchell, 1999). In the present study, the theoretical orientation of the counselors and their experience with specific client populations affected the interventions they undertake and their comfort in specific situations. For instance, a counselor who has worked with children was more likely to be comfortable in issues surrounding experimentation being presented by a teenager. Furthermore, counselors who were systemic in their orientation were likely to include family members in their interventions. The interventions undertaken by the counselors were often appropriate for and congruent with the client’s needs. Past literature has emphasized on the importance of employing “appropriate” evidence-based interventions for being successful as a counselor (Sexton & ERIC Counseling and Student Services Clearinghouse, 1999). However, the study did not ask the counselors to list therapeutic goals; hence, their underlying motivations for using specific interventions could not be elicited.

However, in some instances, pathologizing responses were elicited by the counselors. These responses which were elicited particularly for case scenarios involving diverse gender identity, sexual orientation, and the sexual practice of BDSM may have been influenced by various factors. These factors include counselors’ personal values (Speciale, 2015), the pathologizing of these sexualities by the Diagnostic and Statistical Manual of Mental Disorders (DSM) manual in the past due to the existence of diagnostic codes for such as “gender identity disorder,” “homosexuality”; the continued existence of the diagnostic code of “paraphilias” which subsumes BDSM activities within it (Freeburg & McNaughton, 2017); the absence of counseling literature of sexual practices such as BDSM (Freeburg & McNaughton, 2017) limited training on sexuality in counselor training programs (Freeburg & McNaughton, 2017), and so on.

The influence of therapists’ own values and beliefs was reflected in their own responses. Research has demonstrated the influence of therapists’ values and beliefs on the therapy process (Cottone & Tarvydas, 2003), and this may be true for counseling about issues of sexuality as well. Consequently, literature has emphasized that counselors should be aware of their values and biases (Corey, Corey, & Callanan, 2007) and be able to communicate them to clients in the very beginning of or during the process of counseling and psychotherapy (Cottone & Tarvydas, 2003).
Some of the counselors in the present study adopted a collaborative approach to psychotherapy. Previous literature has elaborated upon the benefit of adopting a collaborative approach versus an expert driven approach to counseling and psychotherapy. This is due to the fact that, as written by Carl Rogers in 1940, “this approach lays stress upon the therapeutic relationship itself as a growth experience” (Kirschenbaum, 1979, p. 113). Another advantage of a collaborative approach can be gleaned from the suggestion by Saint George & Wulff, 2011 as cited in Irby et al., 2012, p. 520) that “The beauty of collaborating is that there are no set roles; there is a flexibility and fluidity that allows for leading and following to be in motion.”

This study demonstrated the role that may be played by the comfort of counselors with issues of sexuality in the interventions undertaken by them. The importance of the counselors’ comfort is rooted in the fact that the element which is common to each therapy framework is the “person” of the counselor who engages with the client in a social relationship (Aponte & Winter, 1987). However, despite of being comfortable, counselors still perceived themselves to be ill-equipped to deal with specific sexuality-related concerns as demonstrated in the “Results” section. This implies that while comfort is linked to perceived efficacy skill (Barnes, 2004; Lent et al., 2006) and expertise, it may still be different from those two concepts.

Conclusion

The present study aimed to understand counselors’ comfort while working with issues of sexuality and explore the interventions undertaken by them upon being presented with such issues in the counseling setup. The counselors perceived themselves as being comfortable with sexuality-related issues and believed that they would be able to manage them without experiencing distress or discomfort. The high level of perceived comfort could be a consequence of a multitude of factors including exposure to issues of sexuality through clients, the media or personal experiences, training in models of counseling, self-perceived competence in working with sexuality-related concerns, personal values of counselors, their knowledge, years of experience, and so on. Furthermore, the counselor’s responses may be influenced by the social desirability bias as there was no measure to check for social desirability.

A varied array of interventions was listed by counselors and most of the interventions listed by counselors were evidence-based. The counselors varied in how directive or non-directive their approach was as well as their engagement with ethical considerations and legal issues. Furthermore, it was found that principles of affirmation, diversity, consent, bodily integrity, and personhood were upheld by some of the interventions described by counselors. However, some responses were reflective of a stance which pathologized and medicalized sexuality.

One of the limitations of the present study was the skewed gender ratio due to the presence of only three female counselors in the sample. This limitation prevents the study from adequately representing the perspectives of male counselors. Furthermore, the presence of a small sample greatly limits the generalizability of the results obtained on the self-constructed comfort scale. The impact of social desirability on participants’ responses was not measured in the study and this may be problematic because social desirability may significantly influence counselors’ responses on various items on the comfort scale.

The study has implications for research as well as counselor training and counseling practice. With regard to implications pertaining to research, the study highlights the need for future research endeavors to focus on the sexuality and counseling, particularly in the context of developing countries such as India. These research endeavors should study larger samples of practicing counselors to be generalizable to the population of interest. Future research should examine the role of sociodemographic factors such as age, gender, years of experience, geographical location, and so on, on counselors’ comfort in working with sexuality concerns and their counseling interventions. Furthermore, research endeavors should examine constructs including counselors’ knowledge of sexuality, their attitude toward issues of sexuality, their personal values, their perceived skill in dealing with such issues, and willingness to engage with such issues as these constructs may influence counselors’ comfort as well as their interventions with issues of sexuality.

With regard to counseling practice, the study illustrates the importance of incorporating sexuality-related concerns into counselor training programs to facilitate the creation of counselors who are able to affirm important facets of the client’s identity. It highlights the necessity for training programs to delve into ethical considerations and laws that may be involved in sexuality-related issues. Furthermore, the study illustrates the need for the availability of supervision for counselors engaging with issues of sexuality which may take the form of peer supervision. This may be gleaned from the fact that counselors end up encountering numerous issues of sexuality and are often not trained to deal with such issues. These issues often involve complex ethical dilemmas and multilayered interventions, thereby requiring constant supervision.

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Note
1. Asking the couple to do things they like doing together (e.g., cooking).

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