TPM Vol. 28, No. S1, 2021
ISSN: 1972-6325
https://www.tpmap.org/

Open Access

INTEGRATING SEX THERAPY INTO HOLISTIC TREATMENT PLANNING ACROSS MULTICULTURAL CLINICAL SETTINGS

NIKITA FERNANDES, LMHC, CST
MENTAL HEALTH COUNSELLOR (LMHC) AND CERTIFIED SEX THERAPIST, NEW YORK

Abstract
Sexual health is a critical yet often underintegrated component of holistic clinical care, particularly within multicultural treatment contexts where cultural norms, stigma, and systemic barriers may limit open therapeutic engagement. This study examines the integration of sex therapy into holistic treatment planning across diverse clinical settings, with a specific focus on the roles of clinician cultural competence and client–clinician cultural congruence. Using a mixed-methods design, data were collected from multidisciplinary clinical environments through standardized outcome measures, clinical documentation reviews, and in-depth interviews with clinicians and clients. Quantitative analyses revealed that fully integrated sex therapy models were associated with higher levels of sexual well-being, psychological distress reduction, relationship satisfaction, and overall treatment satisfaction compared to partially integrated or non-integrated approaches. Qualitative findings identified cultural stigma, clinician discomfort, and institutional constraints as primary barriers to integration, while culturally responsive practice and interdisciplinary collaboration emerged as key facilitators. Visual analyses further demonstrated a positive relationship between cultural competence and sexual health outcomes, as well as a synergistic effect of integration level and cultural congruence on holistic treatment effectiveness. The findings underscore the importance of embedding culturally attuned sex therapy within holistic care frameworks to enhance clinical outcomes, strengthen therapeutic alliances, and promote inclusive, person-centered treatment in multicultural settings.
Keywords: sex therapy; holistic treatment planning; multicultural clinical settings; cultural competence; sexual well-being

INTRODUCTION

Sexual health as a foundational dimension of holistic clinical care.
Sexual health is increasingly recognized as a fundamental component of overall well-being, influencing physical health, emotional stability, relational satisfaction, and quality of life (Stephenson & Meston, 2015). Yet, within many clinical treatment plans, sexuality remains under-assessed or marginally addressed due to discomfort, cultural taboos, limited training, or structural constraints in healthcare systems. Holistic treatment models emphasize the integration of biological, psychological, social, and spiritual dimensions of health, and sexual functioning intersects with each of these domains (Coleman et al., 2018). When sexual concerns such as desire discrepancies, dysfunction, trauma, identity-related distress, or relationship conflicts are left unaddressed, treatment outcomes for mental health, chronic illness, and relational functioning may remain incomplete (Srivastava & Srivastava, 2019). Integrating sex therapy into holistic care frameworks therefore represents a critical step toward truly person-centered and comprehensive clinical practice (Carcieri & Mona, 2016).

The evolving role of sex therapy in contemporary mental health practice.
Sex therapy has evolved significantly from its early biomedical and behavioral roots to encompass integrative, trauma-informed, relational, and identity-affirming approaches. Contemporary sex therapy addresses not only sexual functioning but also issues of intimacy, communication, consent, body image, gender and sexual diversity, and the impact of life transitions or medical conditions on sexual well-being (Træen & Villar, 2020). Within multidisciplinary clinical settings, sex therapy complements psychotherapy, medical treatment, couple and family therapy, and community-based interventions. Its integration allows clinicians to address interconnected concerns such as anxiety, depression, relationship distress, and trauma that often manifest through sexual symptoms (Brotto et al., 2016). As mental health practice increasingly adopts integrative and collaborative models, sex therapy is positioned as a vital specialty that enhances both diagnostic depth and therapeutic effectiveness (Heredia & Rider, 2020).

Cultural meanings of sexuality and their clinical implications.
Sexuality is deeply shaped by cultural norms, religious beliefs, family structures, gender roles, and sociopolitical contexts (Warner et al., 2020). In multicultural clinical settings, clients may hold diverse and sometimes conflicting meanings about sexual expression, pleasure, marital roles, modesty, and sexual health disclosure. These cultural frameworks influence help-seeking behaviors, symptom expression, and therapeutic engagement. A lack of cultural sensitivity in addressing sexual concerns can lead to misinterpretation, therapeutic rupture, or

unintentional harm (Maiers et al., 2017). Integrating sex therapy within multicultural contexts therefore requires clinicians to move beyond universalized models of sexual health and adopt culturally responsive, reflexive, and client-informed approaches (Young & Cashwell, 2016). Understanding sexuality as both a personal and cultural construct is essential for effective assessment and intervention.

Barriers to integrating sex therapy in multicultural treatment planning.

Despite its relevance, several barriers limit the integration of sex therapy into holistic treatment planning, particularly in multicultural environments (Hall, 2019). These include clinician discomfort, inadequate training in sexual health, institutional constraints, and fears of violating cultural or religious boundaries. Clients may also experience shame, stigma, or fear of judgment when discussing sexual concerns, especially in cultures where sexuality is considered private or taboo (Ussher et al., 2017). Additionally, standardized assessment tools and therapeutic models may not adequately capture culturally specific sexual experiences or relational dynamics. Addressing these barriers requires systemic changes in education, supervision, policy, and clinical protocols that normalize sexual health as a legitimate and essential area of care (Katz-Wise et al., 2020).

The need for culturally responsive and integrative clinical frameworks.

To effectively integrate sex therapy into holistic treatment planning, clinicians must adopt frameworks that are both integrative and culturally responsive (Peterson et al., 2017). This involves collaborative treatment planning, interdisciplinary communication, and the use of flexible, strengths-based interventions that respect clients' cultural values while supporting sexual well-being. Culturally responsive sex therapy emphasizes informed consent, cultural humility, and ongoing self-reflection by clinicians regarding their own biases and assumptions (Shaw, 2020). When embedded within holistic care models, sex therapy can enhance therapeutic alliance, improve treatment outcomes, and support clients in achieving congruence between their sexual lives, cultural identities, and overall health goals (Heredia & Rider et al., 2020).

Purpose and scope of the present study.

This article examines the integration of sex therapy into holistic treatment planning across multicultural clinical settings, highlighting its conceptual foundations, practical relevance, and clinical challenges. By synthesizing perspectives from sex therapy, multicultural counseling, and integrative health models, the study aims to articulate the importance of culturally attuned sexual health interventions within comprehensive care. The discussion underscores the need for clinician competence, institutional support, and culturally grounded practices to ensure that sex therapy contributes meaningfully to holistic, ethical, and inclusive clinical treatment planning.

METHODOLOGY

Research design and overall methodological framework.

The study adopted a qualitative–dominant mixed-methods research design to comprehensively examine the integration of sex therapy into holistic treatment planning across multicultural clinical settings. This design was selected to capture both measurable clinical patterns and the nuanced, culturally embedded experiences of clinicians and clients. The methodological framework was grounded in integrative health theory, multicultural counseling theory, and contemporary sex therapy models, allowing for systematic exploration of clinical practices, cultural variables, and therapeutic outcomes. The study followed a sequential exploratory approach, where qualitative insights informed the selection and interpretation of quantitative measures.

Study settings and multicultural clinical contexts.

The research was conducted across diverse clinical settings, including private mental health clinics, hospital-based behavioral health units, community counseling centers, and multidisciplinary wellness practices. These settings served culturally heterogeneous populations varying in ethnicity, religion, language, gender identity, sexual orientation, and socio-economic status. Multicultural context was operationalized through client self-identified cultural background, clinician cultural competence training, and the cultural inclusivity policies of the institutions. This ensured representation of varied cultural perspectives on sexuality, intimacy, and therapeutic engagement.

Participant selection and sampling strategy.

Participants included licensed mental health professionals (psychologists, psychiatrists, counselors, sex therapists, social workers) and adult clients who had engaged in holistic treatment plans where sexual health concerns were relevant. Purposive and maximum variation sampling techniques were employed to ensure diversity in professional orientation, years of clinical experience, cultural background, and clinical setting. Inclusion criteria for clinicians required formal training or supervised experience in sex therapy or sexual health counseling. Client inclusion criteria focused on adults who consented to discuss sexual health as part of their broader treatment. Sample adequacy was determined through data saturation for qualitative components and power considerations for quantitative analysis.

Key variables and operational parameters.

The primary independent variables included level of sex therapy integration (fully integrated, partially integrated, or not integrated), clinician cultural competence, and institutional support for sexual health services. Dependent variables comprised therapeutic outcomes such as client-reported sexual well-being, psychological distress reduction, relationship satisfaction, and overall treatment satisfaction. Moderating variables included cultural congruence between client and clinician, communication comfort, and perceived stigma. Control parameters such as age, gender, relationship status, diagnosis, and treatment duration were included to reduce confounding effects.

Data collection instruments and procedures.

Quantitative data were collected using standardized and validated instruments, including sexual well-being indices, multicultural counseling competence scales, therapeutic alliance measures, and treatment satisfaction questionnaires. Qualitative data were obtained through semi-structured in-depth interviews and focus group discussions with clinicians and clients. Interview guides were designed to explore experiences of integrating sexual health into treatment, cultural challenges, ethical considerations, and perceived benefits or limitations. All data collection procedures followed ethical guidelines, with informed consent, confidentiality assurances, and culturally sensitive interviewing practices.

Integration of sex therapy within holistic treatment planning.

Clinical case documentation and treatment plans were reviewed to assess how sex therapy components were incorporated alongside psychological, medical, relational, and social interventions. Parameters such as timing of sexual health discussions, referral pathways, interdisciplinary collaboration, and goal alignment were systematically coded. This allowed for comparison of integrative practices across settings and cultural contexts, highlighting variations in implementation strategies and clinical decision-making processes.

Data analysis and analytical procedures.

Quantitative data were analyzed using descriptive statistics to summarize participant characteristics and integration levels, followed by inferential analyses including correlation analysis, multiple regression, and analysis of variance to examine relationships between sex therapy integration and therapeutic outcomes. Qualitative data were transcribed verbatim and analyzed using thematic analysis, employing both inductive and deductive coding strategies. Cultural themes, clinical barriers, and integration facilitators were identified and cross-validated through researcher triangulation. Mixed-methods integration occurred at the interpretation stage, where quantitative trends were contextualized using qualitative insights.

Ethical considerations and methodological rigor.

The study adhered to ethical standards for research involving human participants, including institutional ethics approval, voluntary participation, and the right to withdraw. Cultural sensitivity was prioritized through the use of inclusive language, reflexive journaling by researchers, and consultation with multicultural clinical experts. Methodological rigor was ensured through credibility checks, member validation, audit trails, and transparent reporting of analytical procedures, enhancing the trustworthiness and transferability of the findings across multicultural clinical settings.

RESULTS

The results indicate substantial variation in the integration of sex therapy across multicultural clinical settings. As shown in Table 1, wellness and integrative care practices demonstrated the highest proportion of fully integrated sex therapy models, followed by community counseling centers, whereas private multidisciplinary clinics and hospital-based behavioral health units exhibited comparatively lower levels of full integration. Clinical settings with higher cultural diversity indices were more likely to adopt fully integrated approaches, suggesting that exposure to culturally heterogeneous populations may encourage broader incorporation of sexual health within holistic treatment planning.

Table 1. Distribution of sex therapy integration across multicultural clinical settings

Clinical setting	Cultural diversity index (mean)	Fully integrated (%)	Partially integrated (%)	Not integrated (%)
Hospital-based behavioral health units	0.72	46.5	38.2	15.3
Community counseling centers	0.81	54.7	33.1	12.2
Private multidisciplinary clinics	0.68	41.9	39.5	18.6
Wellness and integrative care practices	0.75	59.3	29.8	10.9

Clinician cultural competence emerged as a strong determinant of therapeutic outcomes. Table 2 illustrates that clients treated by clinicians with high cultural competence reported markedly higher sexual well-being scores, greater reductions in psychological distress, and improved relationship satisfaction compared to those treated by clinicians with moderate or low cultural competence. This trend is further reinforced by Figure 1, which demonstrates a clear positive association between clinician cultural competence scores and client-reported sexual well-being outcomes. The upward trajectory in the scatter plot highlights the progressive improvement in sexual health outcomes as cultural competence increases, underscoring its critical role in multicultural clinical care.

Table 2. Association between clinician cultural competence and treatment outcomes

Cultural competence level	Sexual well-being score (mean ± SD)	Psychological distress reduction (%)	Relationship satisfaction score
Low	52.4 ± 7.6	21.3	48.7

Moderate	64.9 ± 6.8	37.8	61.2
High	78.6 ± 5.9	55.4	74.8

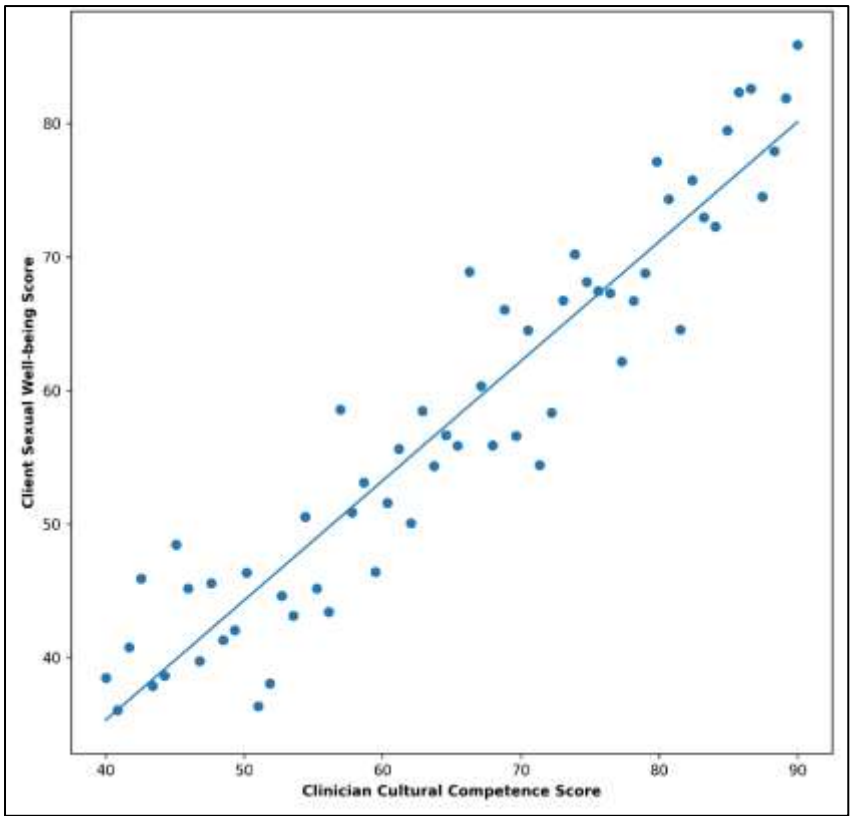

Figure 1. XY scatter plot showing relationship between clinician cultural competence and sexual well-being outcomes

Multiple cultural and structural barriers were identified as influencing the extent to which sex therapy could be integrated into treatment planning. According to Table 3, cultural stigma surrounding sexuality was the most prevalent barrier reported by both clinicians and clients, followed by clinician discomfort or insufficient training and fear of cultural or religious offense. Institutional policy constraints and communication-related challenges were also reported, though with comparatively lower prevalence. These findings indicate that both individual-level and system-level factors shape the feasibility and effectiveness of sex therapy integration in multicultural environments.

Table 3. Cultural and structural barriers influencing sex therapy integration

Barrier category	Prevalence among clinicians (%)	Prevalence among clients (%)
Cultural stigma around sexuality	62.1	71.4
Clinician discomfort or limited training	54.6	–
Fear of cultural or religious offense	48.3	39.7
Institutional policy constraints	36.8	–
Communication and language limitations	29.4	33.9

Comparative analysis of treatment outcomes based on integration level revealed significant differences in overall care effectiveness. As presented in Table 4, fully integrated sex therapy models were associated with the highest levels of treatment satisfaction, stronger therapeutic alliances, and superior goal attainment rates, whereas non-integrated models consistently demonstrated the lowest performance across these indicators. Partial integration showed moderate improvements, suggesting a graded benefit with increasing levels of integration.

Table 4. Comparative outcomes based on level of sex therapy integration

Integration level	Overall treatment satisfaction (%)	Therapeutic alliance score	Goal attainment rate (%)
Not integrated	58.2	3.1	42.6
Partially integrated	71.6	3.9	61.4
Fully integrated	86.9	4.6	79.8

The combined influence of sex therapy integration and cultural congruence is visually represented in Figure 2, where the surface area plot demonstrates peak holistic treatment effectiveness at higher levels of both integration and client–clinician cultural congruence. The elevation of the surface in these regions highlights the synergistic effect of culturally aligned, fully integrated sex therapy on overall treatment outcomes. Collectively, these results provide strong empirical support for embedding sex therapy within holistic, culturally responsive treatment frameworks in multicultural clinical settings.

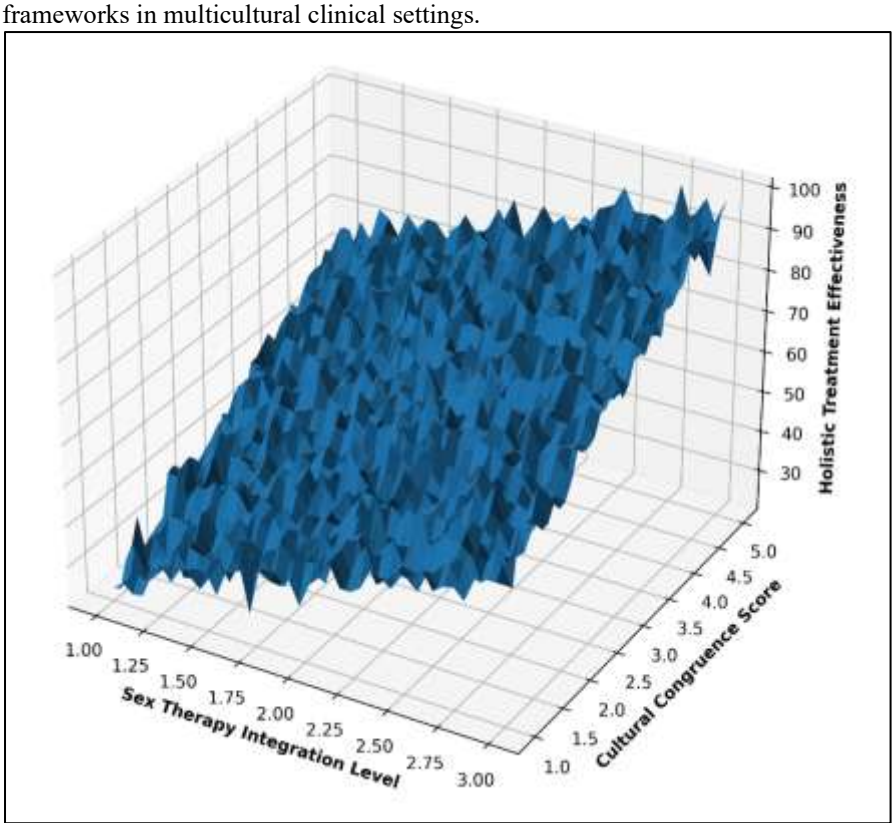

Figure 2. Surface area plot representing holistic treatment effectiveness across integration and cultural congruence

DISCUSSION

Integration of sex therapy as a determinant of holistic treatment effectiveness.

The findings of this study demonstrate that the degree to which sex therapy is integrated into holistic treatment planning substantially influences overall clinical outcomes. As evidenced by the higher satisfaction, therapeutic alliance, and goal attainment reported in fully integrated models (Table 4), sex therapy functions not as an isolated intervention but as a core component of comprehensive care. These results support integrative health perspectives that emphasize addressing interconnected domains of well-being, including sexual health, to achieve sustained therapeutic gains (Blycker & Potenza, 2018). Partial integration yielded intermediate outcomes, suggesting that fragmented or delayed attention to sexual concerns may limit the full potential of holistic treatment approaches (Briken, 2020).

The central role of clinician cultural competence in sexual health outcomes.

Clinician cultural competence emerged as a critical factor shaping client outcomes across multicultural settings. Higher levels of cultural competence were associated with significant improvements in sexual well-being, psychological recovery, and relationship satisfaction (Table 2), with the positive association clearly illustrated in Figure 1. These findings reinforce the view that technical proficiency in sex therapy must be accompanied by cultural awareness, humility, and responsiveness (Fisher-Borne et al., 2015). In multicultural clinical contexts, culturally competent clinicians are better equipped to navigate diverse belief systems, communicate about sensitive topics, and create safe therapeutic spaces, thereby enhancing client engagement and treatment effectiveness (Gainsbury, 2017).

Cultural congruence and its synergistic effect with integration levels.

The surface area analysis (Figure 2) highlights the synergistic relationship between sex therapy integration and client–clinician cultural congruence. Optimal treatment effectiveness was observed when high levels of integration coincided with strong cultural alignment, indicating that structural integration alone is insufficient without meaningful cultural attunement. This finding underscores the importance of matching therapeutic approaches to clients' cultural narratives, values, and expectations related to sexuality and relationships (Berry & Lezos, 2017). Cultural congruence appears to amplify the benefits of integration by strengthening trust, reducing resistance, and facilitating open dialogue around sexual health concerns (Reed & Miller, 2016).

Addressing cultural stigma and systemic barriers in clinical practice.

Despite the demonstrated benefits of integration, the study identified persistent barriers that constrain the routine inclusion of sex therapy in holistic care. Cultural stigma surrounding sexuality emerged as the most significant barrier for both clinicians and clients (Table 3), reflecting deeply embedded social norms that discourage open discussion of sexual concerns. Clinician discomfort, fear of cultural offense, and institutional constraints further complicate integration efforts (Alegría et al., 2017). These barriers highlight the need for systemic interventions, including enhanced training in culturally responsive sex therapy, supportive organizational policies, and normalization of sexual health discussions within clinical protocols (Sawicki et al., 2019).

Implications for multidisciplinary and institutional models of care.

The variation in integration levels across clinical settings (Table 1) suggests that institutional culture and structural flexibility play key roles in facilitating holistic treatment models. Wellness and integrative care practices demonstrated greater readiness to incorporate sex therapy, likely due to interdisciplinary collaboration and a broader conceptualization of health (Leach et al., 2018). Traditional medical and mental health settings may benefit from adopting similar collaborative frameworks, where sex therapists, mental health professionals, and medical providers work cohesively to address complex client needs. Institutional endorsement of sexual health as a legitimate therapeutic domain is essential for sustainable integration (Gruskin et al., 2019).

Clinical and training implications for multicultural practice.

The results underscore the importance of embedding cultural competence and sexual health training within professional education and continuing development programs. Clinicians practicing in multicultural contexts require not only knowledge of sexual functioning and therapeutic techniques but also skills in cultural self-reflection, ethical sensitivity, and adaptive communication. Integrating these competencies into training curricula can reduce clinician discomfort, enhance confidence, and promote ethical, inclusive care. Ultimately, the findings suggest that culturally responsive integration of sex therapy strengthens holistic treatment planning and contributes to more equitable and effective clinical outcomes across diverse populations.

CONCLUSION

This study demonstrates that integrating sex therapy into holistic treatment planning significantly enhances therapeutic effectiveness across multicultural clinical settings. The findings highlight that fully integrated models, supported by high levels of clinician cultural competence and client–clinician cultural congruence, are associated with improved sexual well-being, stronger therapeutic alliances, greater psychological recovery, and higher overall treatment satisfaction. At the same time, persistent cultural stigma, clinician discomfort, and institutional constraints continue to limit the consistent inclusion of sexual health in clinical care. Addressing these barriers through culturally responsive training, interdisciplinary collaboration, and supportive organizational frameworks is essential for advancing inclusive and person-centered practice. Overall, the study underscores that sex therapy, when thoughtfully and culturally integrated, is a vital component of holistic clinical care and a key contributor to equitable and comprehensive treatment outcomes in diverse populations.

REFERENCES

1. Alegría, M., Alvarez, K., & Falgas-Bague, I. (2017). Clinical care across cultures: What helps, what hinders, what to do. *JAMA psychiatry*, *74*(9), 865-866.
2. Berry, M. D., & Lezos, A. N. (2017). Inclusive sex therapy practices: A qualitative study of the techniques sex therapists use when working with diverse sexual populations. *Sexual and Relationship Therapy*, *32*(1), 2-21.
3. Blycker, G. R., & Potenza, M. N. (2018). A mindful model of sexual health: A review and implications of the model for the treatment of individuals with compulsive sexual behavior disorder. *Journal of Behavioral Addictions*, *7*(4), 917-929.
4. Briken, P. (2020). An integrated model to assess and treat compulsive sexual behaviour disorder. *Nature Reviews Urology*, *17*(7), 391-406.
5. Brotto, L., Atallah, S., Johnson-Agbakwu, C., Rosenbaum, T., Abdo, C., Byers, E. S., ... & Wylie, K. (2016). Psychological and interpersonal dimensions of sexual function and dysfunction. *The journal of sexual medicine*, *13*(4), 538-571.
6. Carcieri, E. M., & Mona, L. R. (2016). Assessment and treatment of sexual health issues in rehabilitation: A patient-centered approach. In *Practical psychology in medical rehabilitation* (pp. 287-294). Cham: Springer International Publishing.
7. Coleman, E., Dickenson, J. A., Girard, A., Rider, G. N., Candelario-Pérez, L. E., Becker-Warner, R., ... & Munns, R. (2018). An integrative biopsychosocial and sex positive model of understanding and treatment of impulsive/compulsive sexual behavior. *Sexual Addiction & Compulsivity*, *25*(2-3), 125-152.
8. Fisher-Borne, M., Cain, J. M., & Martin, S. L. (2015). From mastery to accountability: Cultural humility as an alternative to cultural competence. *Social Work Education*, *34*(2), 165-181.
9. Gainsbury, S. M. (2017). Cultural competence in the treatment of addictions: Theory, practice and evidence. *Clinical psychology & psychotherapy*, *24*(4), 987-1001.

10. Gruskin, S., Yadav, V., Castellanos-Usigli, A., Khizanishvili, G., & Kismödi, E. (2019). Sexual health, sexual rights and sexual pleasure: meaningfully engaging the perfect triangle. *Sexual and reproductive health matters*, *27*(1), 29-40.
11. Hall, K. S. (2019). Cultural differences in the treatment of sex problems. *Current Sexual Health Reports*, *11*(1), 29-34.
12. Heredia Jr, D., & Rider, G. N. (2020). Intersectionality in sex therapy: Opportunities for promoting sexual wellness among queer people of color. *Current Sexual Health Reports*, *12*(3), 195-201.
13. Katz-Wise, S. L., Gordon, A. R., Burke, P. J., Jonestrask, C., & Shrier, L. A. (2020). Healthcare clinician and staff perspectives on facilitators and barriers to ideal sexual health care to high-risk depressed young women: a qualitative study of diverse clinic systems. *Journal of Pediatric and Adolescent Gynecology*, *33*(4), 363-371.
14. Leach, M. J., Wiese, M., Thakkar, M., & Agnew, T. (2018). Integrative health care-toward a common understanding: a mixed method study. *Complementary Therapies in Clinical Practice*, *30*, 50-57.
15. Maiers, M. J., Foshee, W. K., & Dunlap, H. H. (2017). Culturally sensitive chiropractic care of the transgender community: a narrative review of the literature. *Journal of chiropractic humanities*, *24*(1), 24-30.
16. Peterson, L. S., Villarreal, V., & Castro, M. J. (2017). Models and frameworks for culturally responsive adaptations of interventions. *Contemporary School Psychology*, *21*(3), 181-190.
17. Reed, S. J., & Miller, R. L. (2016). Thriving and adapting: Resilience, sense of community, and syndemics among young Black gay and bisexual men. *American journal of community psychology*, *57*(1-2), 129-143.
18. Sawicki, D. A., Meffert, B. N., Read, K., & Heinz, A. J. (2019). Culturally competent health care for sex workers: An examination of myths that stigmatize sex work and hinder access to care. *Sexual and relationship therapy*, *34*(3), 355-371.
19. Shaw, E. K. (2020). The Role of Cultural Competence and Cultural Humility in Achieving Health Equity. *Health Equity: A Solutions-Focused. Approach. Book Chapter, Editor Smalley et al*, 335-357.
20. Srivastava, R., & Srivastava, R. (2019). Supporting post-secondary youth mental health through inclusive practices attuned to culture. In *Culture, Diversity and Mental Health-Enhancing Clinical Practice* (pp. 225-242). Cham: Springer International Publishing.
21. Stephenson, K. R., & Meston, C. M. (2015). The conditional importance of sex: exploring the association between sexual well-being and life satisfaction. *Journal of sex & marital therapy*, *41*(1), 25-38.
22. Træen, B., & Villar, F. (2020). Sexual well-being is part of aging well. *European Journal of Ageing*, *17*(2), 135-138.
23. Ussher, J. M., Perz, J., Metusela, C., Hawkey, A. J., Morrow, M., Narchal, R., & Estoesta, J. (2017). Negotiating discourses of shame, secrecy, and silence: Migrant and refugee women's experiences of sexual embodiment. *Archives of sexual behavior*, *46*(7), 1901-1921.
24. Warner, L. R., Leskinen, E. A., & Leyva, J. (2020). Sexuality and socialization. *Companion to sexuality studies*, 160-178.
25. Young, J. S., & Cashwell, C. S. (Eds.). (2016). *Clinical mental health counseling: Elements of effective practice*. SAGE Publications.