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Beverly K. Crump

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Walden University
2018

Abstract

The Lived Experiences of Counselors Working with

Youth with Problem Sexual Behaviors

by

Beverly K. Crump

MA, University of Dayton, 2009

BS, Ohio Christian University, 2006

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Counselor Education and Supervision

Walden University

July 2018

Abstract

Youth, between the ages of 12 and 17, account for the majority of sexual assaults in the United States. Counselors who work with youth with problem sexual behaviors need to have appropriate clinical skills to the degree to which clinical services increase the probability of effective results and are consistent with current professional knowledge. The purpose of this transcendental phenomenological study was to explore the lived experiences of counselors who work with youth with problem sexual behaviors. A purposeful sample of 8 licensed professional clinical counselors employed at a mental health agency in one city in Ohio shared their experiences through semi structured, in-person interviews in their natural settings. The data were collected, transcribed and analyzed using NVivo. The analysis of data conducted through horizontialzation, cluster of meanings, and coding for emergent themes. Transcendental phenomenological approach helped to uncover dominant and influential emotions, which counselors identified as frustration, tension, anger, and fear. The findings for this study revealed that self-care strategies reaffirmed their importance in wellness for appropriate job performance. Furthermore, the participants felt their school program was successful in teaching on various theories however, they indicated a need for more training in working effectively with this specific population. Academic institutions and mental health programs can use the results of this study to amend certification areas on the requirements and clinical skills necessary for counselors working with youth with problem sexual behaviors.

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Dedication

This PhD is dedicated to my mother, for her love and prayers during the challenges of graduate school and life. I dedicated this to my wonderful father who passed away in 2010. To my brothers, Michael, Ken, and Chris, and their wives, Kathy, Sheri, and Charisse who have always been supportive and encouraging. To my nieces and nephews, and other family members who offered help when I needed it most. To my dear friend and mentor, Pete whose guidance and patience taught me to work hard, be persistent, and not give up for the things I aspire to achieve. To all the people whose heart felt prayers kept me going. Last and absolutely not least, to God, without Him I never would have made it

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Chapter 1: Introduction to Study

Introduction

Sexually violent offenses perpetrated by youth account for 16–19% of all sexual crimes committed each year (Seto & Lalimiere, 2010). In fact, youth between the ages of 12 and 17 who sexually offend account for the vast majority of cases of rape and child molestation committed by minors (Efta-Breitbach & Freeman, 2013; Finkelhor, 2012). Stovering, Nelson, and Hart (2013) discussed that counselors working with youth with problem sexual behavior need to have appropriate knowledge, skills, and training to be effective. Ryan, Lane, and Leversee (2010) postulated that counselors who lack prerequisite classes and training to work properly with youth with problem sexual behaviors could become impaired due to counselors inability to function mentally, emotionally and physically in their professional performance. Calley (2009) contended that counselors could become impaired due to unpreparedness to work with youth with problem sexual behaviors, high work demands, and high caseloads. As a result, counselors may experience symptoms associated with frustration, stress, anger, and burnout (Calley, 2009).

Shin, Lee, Kim, and Lee (2012) described burnout as a physical, emotional, and mental exhaustion caused by intense and demanding situations, conditions, or events. Schat and Frone (2011) wrote that people exposed to aggressive actions and conditions are more likely to experience impairment of their social and professional lives and burnout. Furthermore, incompetent counselors are subject to personal discouragement,

loss of enthusiasm, and inability to meet work criteria (Lee, Cho, Kissinger, & Ogle, 2010).

Hayes (2010) conducted a study with 20 mental health counselors who work with youth with problem sexual behaviors in an outpatient mental health facility. The study showed that one-half of the counselors reported anxiety, depression, and burnout due to unpreparedness in understanding how to work with youth with problem sexual behaviors, and inability to maintain their job responsibilities. Chassman, Kotter and Madison (2010) discussed the fact that counselors need dexterity, which is using the knowledge and training proficiently. Therefore, counselors who work with youth with problem sexual behaviors should demonstrate appropriate clinical skills, positive client attitude, and awareness of therapeutic practice. While counseling programs provide counseling students with academic foundations, and counseling-related work through practicums and internships, many mental health counselors are unaware of the occupational hazards of therapeutic practice with youth with problem sexual behaviors (Keim, Olguin, Marley, & Thieman, 2008). It is important for mental health counselors to understand the symptoms associated with occupational stressors that can lead to impairment when working with this population. Counselor impairment is increasing in the mental health field at rates ranging from 20–52% due to high level of stress, role ambiguity, and low levels of training (Baginsky, 2013).

Additionally, studies (Lee et al., 2010; Nelson et al., 2002) demonstrated a lack of understanding of the lived experiences of counselors who provide clinical services to this population. I conducted an extensive search in an effort to understand why information

on prerequisite skills required to counsel youth with problem sexual behaviors was lacking. Increased understanding of the lived experiences of counselors working with youth with problem sexual behaviors could provide the profession with a tangible understanding of the prerequisite skill sets necessary for providing clinical services to this population. Furthermore, this study illuminated counselors' perceptions of the knowledge, skills, and personal attributes essential for providing quality client care to this population. Increased information about prerequisite skills to mental health programs and academic institutions is crucial in refining the skill sets and establishing training curricula needed to work effectively with youth with problem sexual behaviors (Hiebert, 2009). The lack of clinical skill sets has affected counselors' ability to function competently as a counselor (Chassman et al., 2010; Hayes, 2010). In accordance with their ethical principles, counselors have a duty to do no harm, a duty to the well-being of others, and a duty to strive for excellence within the profession (American Counseling Association (ACA), 2014). Therefore, "counselors (must be) alert to the signs of impairment from their own physical, mental, or emotional problems and refrain from providing professional services when such impairment is likely to harm a client or others" (ACA, 2014, p. 9). Counselor impairment influences counselors' professional functioning, which, in turn, compromises client care and can lead to the potential for harm to the client (ACA, 2014). This study provided insight into (a) the lived experiences of counselors working with youth with problem sexual behaviors, and (b) the prerequisite skills needed to decrease impairment and to protect counselors from impairment when working with this population.

Background

Literature on youth with problem sexual behaviors began over a decade ago, but the knowledge gained about this group began in the 1980s because of the increase of youth sexual offender treatment programs (Chaffin, Letourneau, & Silovsky, 2002). In the 1980s, these programs increased primarily because of research conducted that reported information on the need to treat this population (Knopp, Freeman-Longo, & Stevenson, 1992). Historically, treatment approaches for youth with problem sexual behaviors were like intervention models used for adult sex offenders (Riser, Pegram, & Farley, 2013). Advocates for youth with problem sexual behaviors argued for increased understanding about the developmental, motivational, and behavioral differences between youth sex offenders and adult sex offenders. The therapeutic interventions that resulted are different for youth sexual offenders; they respond specifically to youth's sexually abusive behaviors (McGarth, Cumming, Burchard, Zeoli, & Ellerby, 2010). Mental health counselors utilizing interventions for youth with problem sexual behaviors are at risk for stress, discouragement, and impairment by not having the appropriate clinical skill sets and training (Calley, 2009; Hayes, 2010; Geradin and Thibaut ,2004; Nelson et al., 2002). Issues surrounding professional impairment date back to 1884 because of deficits in counselors' performance that needed improvement (ACA, 2014). In 1958, the Federation of State Medical Boards recognized impairment among mental health professionals and developed rehabilitation and wellness programs to help stabilize clinicians who work with high-risk populations (American Psychological Association, 2014). In 2003, the ACA created a task force program to investigate counselors

experiencing impairment. Steen and Monnette (1989) discussed the need for mental health programs to use caution on employing counselors who did not possess the appropriate skill sets to work with youth with problem sexual behaviors. Additionally, Nelson et al., (2002) argued for academic counseling programs to establish more curriculum courses to better prepare students who choose to work with youth with problem sexual behaviors. Literature suggests that early preparation and training could better prepare counselors to work with youth with problem sexual behaviors and prevent impairment and burnout (Neslon et al., 2002; Stovering et al., 2013). A gap exists in the literature, which is information on the lived experiences of mental health counselors who work with youth with problem sexual behaviors and their perceptions of the necessary clinical skill sets to prevent counselor impairment. This study illuminated counselors' perceptions of knowledge, skills, and training necessary for providing effective counseling services to youth with problem sexual behaviors and for decreasing the risk of counselor impairment when working with this population.

Problem Statement

Youth, between the ages of 12 and 17, account for the majority of sexual assaults in the United States (Seto & Lalimiere, 2010). Counselors who work with youth with problem sexual behaviors need to have the appropriate clinical skills because clinical services increase the probability of effective results and are consistent with current knowledge (Efta-Breibach & Freeman, 2013; Finkelhor, 2012). Stovering, Nelson, and Hart (2013) postulated the necessity for mental health practitioners working with youth with problem sexual behaviors to have appropriate clinical skills to the degree to which

clinical services for clients increase the probability of effective results and are consistent with current professional knowledge. Therefore, counselors working with youth with problem sexual behaviors should attain professional competence to work with this population. Impairment is a form of burnout (Shin, Lee, Kim, & Lee, 2012) which can lead to impairment of social and professional life (Schat & Frone, 2011)

There is a range of skills needed on knowledge, training, and expertise however; the lack of these can adversely affect the counselors' effectiveness (Chassman, Kotter, & Madison, 2010). Counselors experiencing impairment are ethically bound to comply with professional codes established by the American Counseling Association (ACA, 2014). Counselor impairment influences counselors' professional functioning that compromises client care or has the potential for harm to the client (ACA, 2014).

The literature is limited on prerequisite skills required for counselors to work with youth with problem sexual behaviors (Hayes, 2010; Lee et al., 2010; Nelson et al., 2002). Additionally, research shows the limited understanding of the lived experiences of counselors who provide clinical services to this population. Increased understanding of the lived experiences of counselors working with youth with problem sexual behaviors could provide the profession with an understanding of the prerequisite skill sets necessary for providing clinical services to this population. Furthermore, this study illuminated counselors' perceptions of the knowledge, skills, and personal attributes essential for providing quality client care. Increased information about prerequisite skills to mental health programs and academic institutions is crucial in refining the skill sets and establishing training curriculum needed to work effectively with youth with problem

sexual behaviors (Hiebert, 2009). This study attempted to understand the essence of the lived experiences of counselors working with youth with problem sexual behaviors, and the perception of the prerequisite skills needed to decrease impairment and to protect counselors from impairment.

Purpose of the Study

The purpose of this transcendental phenomenological study was to understand the lived experiences of counselors who work with youth with problem sexual behaviors. This research endeavored to illuminate the prerequisite skills needed when working with this population. Additionally, information obtained can lead to better training programs so that counselors have decreased risk for impairment. This research generated further understanding of the needs of youth with problem sexual behaviors by exploring the experiences, beliefs, opinions, attitudes, and perspectives of their counselors. Greater understanding of the lived experiences of these counselors highlighted the information needed to help counselor educators prepare counselors-in-training who choose to work with youth with problem sexual behaviors.

Research Question

The following question guides this study: What are the lived experiences of counselors who work with youth with problem sexual behaviors?

Conceptual Framework for the Study

When investigating the beliefs, perspectives, and lived experiences of counselors the phenomenological view provided a glimpse of the phenomenon from the individuals' experiences through rich description. Moustakas (1994) described the phenomenological view as the ability to explore the phenomenon through the subjective eyes of the people involved. This descriptive process provided an opportunity to explore the experiences of the participants and avoid judgment and bias (Moustakas, 1994). The goal of transcendental phenomenology combines the lived experiences of all participants into a cohesive common description of the phenomenon of interest (Moustakas, 1994).

Phenomenology originated from Edmund Husserl (1931) who described phenomenology as the sustained attempt to describe experiences without abstract thoughts and subjects (metaphysical) or speculative knowledge or logical deductive thoughts (theoretical). Husserl suggested that only by temporarily presenting or bracketing away the natural attitude could philosophical thoughts become their own distinctive feature of science (Hanna, 2014; Husserl, 1931). Taipale (2015) wrote that Husserl's approach to understanding human experience is the main factor that led to the development of transcendental phenomenology. Husserl's philosophical

underpinnings of transcendental phenomenology are grounded on the concept that preconceived ideas (*epoch*) see the phenomenon in its true form, and as a result, allowing the true meaning of the phenomenon to innately emerge within its own identity (Hanna, 2014; Taipale, 2015). Luft (2011) found that in transcendental phenomenology, the participant's conscious thoughts progress into their perceptions, realities, and truths. Thus, transcendental phenomenology conveys an overall essence of the participants' lived experience. The researcher obtains descriptions and details systematically from the perspective of the individuals being studied (Englander, 2012). Additionally, the researcher distinguishes the difference between transcendental phenomenology and hermeneutic phenomenology in that the latter does not focus on the researchers' interpretation of the information common to hermeneutic phenomenology (van Manen, 2014).

Utilizing this framework allowed the exploration of the lived experiences, perceptions, and beliefs of counselors who are currently working in the counseling field with youth with problem sexual behaviors. The systematic approach used for analyzing the information allowed the researcher to understand the lived experiences as described by the counselors who work with youth with problem sexual behaviors.

Nature of the Study

This transcendental phenomenological study sought to uncover the lived experiences of counselors working with youth with problem sexual behaviors. A phenomenological approach allowed participants to express their opinions, thoughts, and beliefs in the lived experiences of counselors (Creswell, 2013; Denzin & Lincoln, 2011;

Moustakas, 1994; Patton, 2015). This inquiry included one semi structured 60-minute, in-person interview, in which participants provided a deeper description of the issue (Creswell, 2013; Luft, 2011; Moustakas, 1994). Semi structured interviewing used open-ended questions, which allowed both the researcher and the participants the flexibility to explore details of the discussion (Creswell, 2013; Moustakas, 1994). The participants' responses provided an understanding of their subjective experience of the phenomenon. Thus, a phenomenological inquiry helped to develop a clear and rich description of the participants' account of the experience and provided understanding of the meaning of impairment.

Definitions

This section defines the key of the study in order to distinguish its meaning for this dissertation.

Youth with Problem Sexual Behaviors – The Office of Juvenile Justice and Delinquency Prevention (OJDP) (2009, 2016) described youth with problem sexual behaviors as children and youth who engage in sexually aggressive and abusive behaviors against minors. Youth who are sexually aggressive and abusive in a sexual nature inflict actions without consent, without equality, and of coercion, manipulation, and deception (Seto & Lalimiere, 2010).

Burnout – Burnout originated in 1975and refers to incapacitating exhaustion (Lee, Cho, Kissinger, & Ogle, 2010). Shin, Lee, Kim, and Lee (2012) described burnout as an overstressed state of continuous emotional, physical, and mental exhaustion caused by intense situation and conditions.

Clinical skill sets – described as a solid set of essential skills used by mental health professionals to perform acceptably those duties directly related to client care (Bradley & Ladany, 2010). Bernard and Goodyear (2009) refer the term to clinicians who are able to identify the unique needs of clients and are effective in providing accurate diagnosis, interventions, and treatment plans.

Licensed Professional Clinical Counselor (LPCC) – The American Counseling Association (ACA) (2014) described licensed professional clinical counselors as mental health service providers who have academic masters' degree, and are trained to provide clinical services to individuals, families, and groups in treating mental, behavioral, and emotional problems and disorders.

Professional impairment – The American Psychological Association (APA) (2010) described professional impairment is interference in the professionals' life that prohibits their ability to perform their job to the best of their ability, and sometimes in a manner that can be unethical and unprofessional.

Subjective experience – The term derived from a phenomenological view in that a theory of consciousness, ideas, concepts, images, propositions, and meanings serves as intentional content of the persons' experience (Kolb, 2014; Nagel, 1974).

Assumptions

The following assumptions for this study are: (a) the participants responded in an honest and candid manner. (b) The inclusion criteria of the sample are appropriate and therefore, assure that the participants have all experienced the same or similar

phenomenon of the study. (c) The participants have a sincere interest in participating in this research and do not have any other motives.

Scope and Delimitations

The scope and delimitations of this study were the boundaries of study are; (a) the participants had to be licensed professional clinical counselors who had 1–3 years of clinical experience working with youth with problem sexual behaviors, (b) and lived in a city in Ohio. Excluded in this study are: (a) counselors who are not LPCCs, (b) more than 3 years of experience, (c) counselors who lived outside a city in Ohio. Generalizability might not be a concern in exploratory study such as this if it can provide additional avenues of research inquiry and a better understanding of the phenomenon. The conceptual frameworks most related to this area of study but not investigated included hermeneutics, narrative, ethnomethodology, network analysis, and thematic analysis. The delimitations allowed me to explore the research question thoroughly and obtain a rich description of the lived experiences of counselors working with youth with problem sexual behaviors and the meaning ascribed to professional impairment.

Limitations

The limitations of this study are; (a) sample population of LPPCs, (b) 1-3 years of clinical counseling, and (c) counselors assigned to youth with problem sexual behaviors and specializes in diagnosis and treatment. The limitations of the study related to methodology are; (a) details of the data might not be genuine, (b) participants might not be able to articulate their thoughts and feelings, (c) this study

can be duplicated but might not obtain the same results, (d) difficulty obtaining participants, (e) this study apply to a specific group, and (f) generalizability for the sample size was only for one city in Ohio. The issues related to limitations of internal validity includes; (a) the interview questions were asked of participants in the same order, and (b) all the participants appeared to be comfortable during the interview sessions. The limitations regarding external validity are; (a) the program impact apply specifically to counselors with similar characteristics, (b) the program could be applied in a different setting with different results, and (c) this study could be utilized for future studies and receive similar results. Limitation in terms of construct validity was the sampling size of LPCCs working with youth with sexual behavior problems. For this study, there were no confounder variables. To limit bias that could influence the study outcomes bracketing prevented researcher bias from the data obtained from the participants. Additionally, to limit participation bias, the interview questions were open-ended.

Significance

Counselors working with youth with problem sexual behaviors are at risk of experiencing several symptoms: stress, frustration, anxiety, and impairment (Bohart & Tallman, 2010). A counselor's lack of clinical skill sets can damage the relationship between the counselor and client because of impairment that affects the counselors' ability to provide appropriate clinical services (Ducharme, Kunden, Abraham, & Roman, 2010). Underwood, Robinson, Mosholder, and Warren (2008) found that counselors who failed to obtain the required clinical skill sets would be incapable of

"identifying and treating adolescent perpetrators" (p. 2). Researching the lived experiences of counselors working with youth with problem sexual behaviors increased knowledge and understanding. Increased information helped explain the clinical skill sets needed to advance counselors' professional development and growth and prevent impairment. Considerable understanding and knowledge heightened awareness and helped ensure that mental health counselors are competent in meeting the needs of youth with problem sexual behaviors and avoid professional impairment.

Therefore, the potential contributions to this study are; (a) enhance perceptions of future counselors who work specifically with youth with problem sexual behaviors, and (b) advance practice and/or policy in the fields of training and professional development. The implications for social change consistent with and bounded by the scope of the study are; (a) heighten awareness of the prerequisite skills needed to effectively treat youth with sexual behavior problems, (b) increase understanding on the clinical skills most effective for quality client care and outcomes, and (c) information obtained can emend certification areas closely associated to the requirements and clinical skill sets necessary working with youth with problem sexual behaviors.

Summary

Youth, between the ages of 12-17, account for the majority of sexual assaults in the United States. Counselors who work with youth with problem sexual behaviors need to have the appropriate clinical skills because clinical services increase the probability of effective results and are consistent with current knowledge. The literature is limited on research studies showing the prerequisite skills required for counselors working with

youth with problem sexual behaviors. Increasing knowledge and understanding might heighten perceptions of the prerequisite skills necessary to increase counselor's perceptions of the clinical skills most effective for positive outcomes and prevent counselors from impairment.

Chapter 2 provides a review of studies that addressed the issues counselors encountered described through challenges, occupational hazards and academic deficiencies. I included an overview of professional impairment with the detrimental effects to counselors and impact to mental health organizations and academic institutions. I also reviewed the studies conducted on the ethical issues in counseling and counselor competence to explain some of the identified causes, and treatment model approaches that are most suitable for youth with problem sexual behaviors.

Chapter 3 provides the methodology of this study. In this study, transcendental phenomenology systematically collected facts that describe in detail the experiences of mental health practitioners working with youth with problem sexual behaviors. LPCCs participants have experience with situations, conditions, and events with the phenomenon to obtain their perspectives working with youth with problem sexual behaviors. I recruited LPCCs from diverse backgrounds, at least 3 years of experience, different cultures, and ethnicities so that the study's findings are fair and unbiased. In this study, I used a phenomenological approach to collect data through instrumentation of in-person interviews, transcription, and observation. Transcribing data helps the researcher obtain greater understanding of the participant's experience of the phenomenon. I transcribed the interviews for accuracy of the generated meanings and

perceptions shared by participant during the interviews. I analyzed the data through horizontialzation, cluster of meanings, and coding for emergent themes. Chapter 4, the results of the study's findings, includes three themes that emerged from the data included: (1) personal responsibility, (2) self-care, and (3) training.

Chapter 5 provides the recommendations and conclusion of the study. Based on the evidence, recommendations for this study included, academic institutions to have a curriculum that specifically address youth with problem sexual behaviors, and mental health agencies that provide counseling services to youth with problem sexual behaviors incorporate additional professional development, workshops, and trainings to counselors.

Chapter 2: Literature Review

Introduction

Youth, between the ages of 12 and 17, account for the vast majority of sexual assaults in the United States (Seto & Lalimiere, 2010). Studies conducted by Efta-Breibach and Freeman (2013) and Finkelhor (2012), showed that one-fifth of rapes and one-half of child molestations are committed by youth under 18 years of age. If clinical services are to be effective for diagnosis and treatment, as well as consistent with current professional development, then mental health practitioners working with youth with problem sexual behaviors need to have the appropriate skill sets and training. (Stovering, Nelson, & Hart, 2013). Counselors who lack the appropriate clinical skills to counsel youth with problem sexual behaviors are at risk of professional impairment (Ryan, Lane, & Leversee, 2010). Impairment is a form of burnout that causes a provider to be in a debilitated state physically, mentally, or emotionally (Lee et al., 2012; ACA, 2014). According to the literature, the professional performance of mental health counselors who are exposed to aggressive behaviors without proper clinical skill sets and training can become impaired (Keim et al., 2013; Shatt & Frone, 2011). In this chapter, I review the literature on the experiences of mental health practitioners counseling youth with problems sexual behaviors, and the clinical skill sets necessary to decrease impairment and to protect counselors from impairment.

Literature Search Strategy

To conduct the search for relevant literature, I used the following databases: Google Scholar, PsycINFO, and PsycARTICLES. The articles date from the 1980s to

the present and identify available data relevant to adolescent sexual offenders, counseling adolescent sexual offenders, and counselor impairment. The following keywords was used: *youth with problem sexual behaviors, counseling challenges and controversies with youth with problem sexual behaviors, professional impairment, impaired counselors, diagnosis and treatment of youth with problem sexual behaviors, transcendental phenomenology, saturation, trustworthiness, and ethical responsibility.* Additionally, I searched the bibliographies of existing reviews and studies for additional data on the topic.

Conceptual Framework

The conceptual framework for this study is transcendental phenomenology. This provided a detailed description of the phenomenon as experienced by the participants in the study (Moustakas, 1994). Edmund Husserl (1931) established the school of phenomenology and discovered that the structure of human consciousness, and describing those structures, is the bases for human knowledge (Husserl, 1931). Husserl stated that phenomenology is the study of (a) the ways human experience and directed toward a particular object in the world and (b) the conscious experience or first-person point of view. Hanna (2014) contended that Husserl's qualitative research methodology approach to understand human experience is the contributing factor that leads to the development of transcendental phenomenology. Husserl's philosophical foundation of transcendental phenomenology are based on seeing the phenomenon in its true form and allowing the true meaning of the phenomenon to naturally emerge within its own identity (Taipale, 2015).

Moustakas (1994) contended that transcendental phenomenology is a detailed description of a phenomenon through the subjective eyes of the individual. Luft (2011) discussed how transcendental phenomenology gathered descriptive information that analyzed the person's awareness, consciousness, and understanding of their experience. Transcendental phenomenology differentiates from hermeneutic phenomenology in that it does not focus on the researcher's explanation of the information common to hermeneutic phenomenology (van Manen, 2014). In this study, transcendental phenomenology allowed for an accurate description of the experiences, perceptions, and beliefs of mental health practitioners who provide clinical services to youth with problem sexual behaviors. Importantly, transcendental phenomenology provided the framework for accurately examining the mental health practitioner's perception of youth with problem sexual behaviors, and their understanding about the clinical skill sets needed for effective diagnosis and treatment.

Literature Review Related to Key Concepts

Origin of Youth with Problem Sexual Behaviors

There are inconsistencies in the literature when describing youth with problem sexual behaviors (Etgar, 2012). Terms such as, child molester, youth sexual abuser, and youth perpetrator describe, label, and stigmatize youth with sexually aggressive behaviors (Etgar, 2012). Etgar and Neder (2008) commented that youth who sexually abuse are different from adult sex offenders because of developmental behavior patterns, level of maturity, and learning styles. Therefore, knowledge base, concepts, methods, and terms used to describe youth with problem sexual behaviors differentiate

from adult sex offenders (Chaffin, 2010). Longo and Prescott (2006) referred to studies conducted by McGarth, Cumming, and Burchard (2003) that showed no empirical-based evidence to support the concept that youth with problem sexual behaviors experience sexual aggressive behaviors similar to adult sexual offenders. Until the 1980s, the primary focus of research and treatment was on adult sexual offenders (McGarth, Cumming, Burchard, Zeoli, & Ellerby, 2010). The treatment plans for adult sexual offenders are the basis for the plans for youth with sexual behavior problems (Chaffin, Letourneau, & Silovsky, 2002; Knopp, Freeman-Longo, & Stevenson, 1992). Several studies exist that presented evidence-based documentation of differences between youth with problem sexual behaviors and adult sexual offenders in maturity level, learning styles, challenges, risks, and needs (Cooke, Michie, & Hart, 2006; Douglas, Vincent, & Edens, 2006; Edens, Poythres, Litlenfield, & Patrick, 2008).

The Association for the Treatment of Sexual Abusers (ATSA) presented an accurate description of youth with problem sexual behaviors as youth, ages 13 to 18 years, with sexual behavior problems and differentiated from adult sexual offenders by instances of sexually aggressive actions and developmental behaviors (ATSA, 2015). Further discussion on youth with problem sexual behaviors followed in the subtype categories that included mental health practitioners and youth with problem sexual behaviors, and treatment models for youth with problem sexual behaviors.

Counseling and Youth with Problem Sexual Behaviors

Mental health practitioners encountered many issues when providing counseling services to youth with problem sexual behaviors (Moulden & Firestone, 2007). Mental health counselors with minimal knowledge and clinical skills to counsel youth with problem sexual behaviors are prone to stress, frustration, discouragement, and impairment (Chassman, Kottler, & Madison, 2010). Ryan, Lane, and Leversee (2010) contended that professional and ethical issues occur when counselors lack the proper understanding, skills, and training to counsel youth abusers. Minimal attention directed to the issues on the impact of counselors who work with youth with problem sexual behaviors (Stovering, Nelson, & Hart, 2013). Research studies (Hogue, 1993; Nelson et al., 2002; Ward, Connally, McCormack, & Hudson, 1996) showed results on the negative attitudes of counselors towards youth with problem sexual behaviors based on perceptions and distorted thinking. As a result, this attitude changes counselors' views that identifies youth with problem sexual behaviors as criminals who need punishment instead of clients who need counseling services (Nelson & Hart, 2013). For this reason, mental health practitioners are to adhere to the American Counseling Association ethical guidelines to work within the scope of their competence and recognize symptoms of impairment that disrupts their ability to function professionally and socially (ACA, 2014).

Challenges and Controversies for Mental Health Practitioners

Research on youth with problem sexual behaviors has emerged as data uncovered from the past decade demonstrated an increase of 20% of youth involved in

criminal sexual behaviors (Ford & Blausten, 2013). Mental health practitioners working with youth with problem sexual behaviors encountered challenges and controversies such as occupational hazards, academic deficiency, ethical concerns, and professional impairment. This exploration provided awareness of these challenges and controversies that generated further knowledge and understanding in the field (Brennan, 2013; Carter & Barnett, 2014; Ford & Blaustein, 2013; ACA, 2003). Increased information and knowledge ensured that mental health practitioners are competent in meeting the needs of youth with problem sexual behaviors and prevent professional impairment (ACA, 2014; Chassman et al., 2010; Nelson & Hart, 2013; Remley & Herlihy, 2010).

Occupational Hazards

Linnerooth, Mrdjenovich, and Moore (2011) discussed work challenges for counselors who provide counseling services to youth with problem sexual behaviors. These challenges are through intense face-to-face interaction and confrontation with clients. As a result, counselors are incapable to function professionally because of stress reactions, discouragement, and burnout. Oser, Biebel, Pullen, and Harp (2013) contended that mental health counselors working in the public sector with youth sexual offenders often experience vicarious or secondary trauma caused by the emotional exposure of pain, fear, and terror of their client experiences. The ACA (2015) described vicarious trauma for professionals as having difficulty in their professional role and function. Additionally, professionals are incapable of making reasonable decisions and sound judgment.

Newell and MacNeil (2011) focused on studies pertaining to job burnout for mental health practitioners who work with high- risk youth. The study showed that exposure to stressors and conditions, direct contact with trauma individuals, and individuals who use intent and force to harm others are relative to the counselor's well-being and quality of life (Beck, 1993; Beck & Beck 2011). Vicarious trauma focuses on cognitive effects of indirect exposure (Pearlman & Saakvitne, 1996). The symptoms of vicarious trauma are based on five disturbances in the professional's cognitions; (a) welfare and well-being, (b) confidence, (c) respect, (d) relationships, and (e) loss of control to oneself or others (Pearlman & Saakvitne, 1996). Therefore, mental health practitioners consistently exposed to trauma work conditions, situations, or events are in danger of vicarious trauma due to continuous indirect exposure to trauma work (Beck & Beck, 2011).

Academic Deficiency

Mental health counselors who choose to work with youth with problem sexual behaviors need to be competent in knowledge, skills, and training to provide the appropriate clinical services to this population. Stovering, Nelson, and Hart (2013) contended that counselors working with youth with problem sexual behaviors lack the appropriate level of education, expertise, and instruction to produce effective mental health services for their clients. Chassman, Kotter, and Madison (2010) focused attention on the problem that exists in academia that includes academic or pre-service counseling programs, and counselors that lack the necessary skill sets in diagnosis and treatment of youth with problem sexual behaviors. Additionally, Nelson et al., (2002)

argued for academic and mental health programs to recognize the need for current and future counselors to have specific clinical skill sets working with youth with problem sexual behaviors. As such, mental health counselors who do not have the appropriate clinical skills and training to counsel youth with problem sexual behaviors can experience professional impairment caused by an inability to understand the clinical services needed for this population.

Professional Impairment

The origin of professional impairment for healthcare professionals was first, identified in 1884 by Sigmund Freud who became addicted to cocaine to help his best friend and colleague who was addicted to morphine (Tartakosky, 2011). It was not until 1958, that the Federation of State Medical Boards identified impairment as a serious problem among healthcare professionals in the United States (APA, 2004). The issues affecting professional functioning continued to increase as mental health and other healthcare professionals exhibited symptoms of emotional, mental, and physical distress (Shallcross, 2011). Brennan (2013) contended that counseling is emotionally draining for mental health practitioners.

Thus, mental health practitioners are to monitor their mental and emotional well-being to be effective and successful counselling clients (ACA, 2014; Brennan, 2013). In 1991, the ACA continued discussions that addressed efforts to help professionals in the field as an estimated 10% of counseling professionals demonstrated some form of impairment (ACA, 1991; ACA, 2014). As a result, of the increase of professionals impaired in 1991, the ACA created the first task force and interventions program s that

assisted counselors who are impaired and promoted counselor wellness (ACA, 1991; Epstein & Hunder, 2002). In 2003, the ACA developed a second task force that specifically addressed plans, programs, and policies for impaired counselors. Additionally, the task force created a working definition of counselor impairment to employ as a work guide that targeted counselors impaired who demonstrate significant stressors that are inherent through occupational hazards and deficient in the level of clinical competence (ACA Taskforce, 2003).

The ACA (2014) described the term impairment as counselors who are incompetent of performance in professional responsibilities or professional services due to personal, emotional, mental or physical difficulties. Additionally, the ACA (2014) indicated that counselors impaired are negative in their approach to deliver and monitor professional services and quality care for clients. Baldisseri (2007) asserted that counselors impaired are incapable of maintaining work or social obligations or interact and thing in a reasonable manner without mistakes. Signs of impairment as discussed by Emerson and Markos (1996) are manifested by symptoms of depression, stress and anxiety, chemical and alcohol abuse, exploitation of clients, chronic physical illness, over-involvement and over work, temporary emotional imbalance, contagion, and burnout. Furthermore, impairment may associate to issues relating to violation of professional boundaries and unethical behavior (Thompson, Amatea, & Thompson, 2014).

The ACA (2014) contended that ethical behaviors influenced by moral principles focus on human behavior and moral decisions. Therefore, ethical behaviors

are principles and standards that govern the counselor- client relationship (Pack-Brown, Thomas & Seymour, 2008). Welfel (2010)) discussed that mental health practitioners demonstrating ethical behaviors are noteworthy being reliable, respectful of client's rights, promote client's health and happiness, avoiding or preventing trauma or injury to clients, providing fair and equal treatment and care of clients, and recognizing one's self- knowledge and care. Welfel (2010) went on to say that, mental health practitioners demonstrate personal moral values, empathy to individual experiences, genuineness, truthfulness, expertise in the field, fairness in decisions and actions, intelligence, and courage in standing up for their beliefs (Welfel, 2010).

As such, the issues of professional impairment continue to present real-life challenges for mental health counselors and other healthcare professionals. To prevent impairment mental health professionals can develop a professional self-care plan to manage occupational stressors and maintain professionalism (Carter & Barnett, 2014). Moreover, Carter and Barnett (2014) asserted that a professional self-care plan requires meeting frequently with a supervisor or seeking out advice from colleagues with more experience and expertise, maintain boundaries amongst clients and staff, and attend professional development workshops and trainings. Additionally, Barnett and Sarnel (2003) indicated that self-care strategies assist to enhance the mental health professionals overall well-being. As such, the information presented show a need for further investigation of dominate conditions, situations, events, and people that influence and disrupts the quality of mental health services implemented by counseling professionals. (Thompson et al., 2014).

Ethical Issues in Counseling

Ethical principles and behavior are components built on, compassion and sensitivity, right and wrong of human conduct, actions derived from moral and ethical principles, and life-long commitment based on ethical decisions (Knapp & Vandecreek, 2012; Pope & Vasquez, 2011). Gottlieb, Handelman, and Knapp (2008) commented that ethical challenges occur for counselors during their practice that can affect their professional values and professional identity. Welfel (2010)) asserted that counselors might prevent unethical behavior by developing an understanding of the elements that creates and maintain ethical and proficient implementation in practice. The ACA (2014) cautioned that counselors are to dismiss unethical behavior that interferes with competence in the profession, respect for human dignity and life, and the welfare of the client. Furthermore, Welfel (2010)) indicated that professional ethics helps counselors understand a broader view of making decisions based on morality. There are many ethical challenges for mental health practitioners that might cause them to question their ethical intelligence. Pope and Vasquez (2016) described ethical intelligence as a process of constant perception involving one’s personal responsibility. Ethical intelligence empowers individuals to recognize challenges and make choices that are logical (Wickham & O’Donohue, 2012). Although ethical intelligence is essential for counseling professionals, there are additional ethical considerations for mental health practitioners who counsel minors or youth under 18 years of age. As such, Remley and Herlihy (2010) found that counselors working with

minors are challenged with ethical issues surrounding, confidentiality, counselor competence, and reporting child abuse and child neglect.

Confidentiality

The ACA (2014) Ethical Codes of Standards contended that counselors are to maintain information that clients have disclosed. However, parents of minor clients have a legal right to any information disclosed by the minor client until they reach 18 years of age. Herlihy and Corey (2006) argued that counselors are often “caught between allegiance to their minor clients and the legal reality of parental rights” (p. 201). Standard A.2 of the ACA (2014) discussed clients who have the right to informed consent, as well as, the choice to remain in counseling, and know what their rights and responsibilities include, in addition, to the rights and responsibilities of the counselor. Remley and Herlihy (2010) commented on the importance of parents or legal guardian of the minor client to understand confidentiality due to information the minor client does not want revealed. However, it is necessary for the counselor to understand that breaking confidentiality is permissible when the minor client is in danger or threatens to harm themselves or others. In this regard, counselors are obligated to inform the parents or legal guardian of such actions by the minor client (ACA, 2014; Remley & Herlihy, 2010).

Counselor Competence

Counselor competence are the boundaries of competence by which mental health practitioners provide professional counseling services as a result, of their knowledge, skills, training, and qualifications (ACA, 2014). This is specifically

essential for counselors who work with minor clients who are especially susceptible to harm (Remley & Herlihy, 2010). In this regard, mental health practitioners must understand the limitation of their practice and provide services within the extent of their experience, education, and skills (ACA, 2014; APA, 2010).

Reporting Child Abuse and Child Neglect

The problem of child abuse and neglect has existed throughout history in the United States, and across the globe (Finkelhor, Turner, Ormond, & Hamby, 2013). The Center for Disease Control (CDC, 2012) Division for Violence Prevention, reported in 2012, an estimated 3.4 million children were victims of maltreatment in the United States. The U.S. Department of Health and Human Services provide data which showed that 78% of children were victims of neglect, 18% of physical abuse, 9% of sexual abuse, and 11% were victims of emotional abuse, parents addiction and alcohol abuse or minimum supervision or care (U.S. Department of Health and Human Services, 2012). It is imperative for mental health counselors to report any signs of child abuse and neglect. The American Mental Health Counselors Association (AMHCA, 2010) emphasized the importance for mental health counselors to report child abuse and neglect, and failure to report is a breach of the law and ethical standards. Additionally, Lawerence and Kurpius (2000) commented that reporting child abuse might be difficult for the practitioner due to the negative ramifications on the client, counselor, and family. However, it is crucial for the counselor to report suspected child abuse and neglect for proper client care and treatment (Herlihy & Corey, 2006). When reporting child abuse and neglect counselors need to collect

accurate evidence and information, and report to the appropriate authorities (AMHCA, 2010; Thornberry, Henry, Ireland, & Smith, 2010).). Additionally, Herlihy and Corey (2006) contended that counselors should keep in mind the consequences that can follow when reporting child abuse and neglect and that counselor's consult with professionals in the field and obtain legal counsel in the case of future legal actions. Counseling professionals have a professional and ethical responsibility to maintain a positive and healthy attitude with respect for the client, colleagues, and community. Therefore, mental health practitioners recognized unethical behavior that compromised the client-counselor relationship, as well as the counselor's ability to function in a professional manner because of impairment caused by unethical practice.

Treatment Models for Youth with Problem Sexual Behaviors

Youth with sexual abusive behaviors are a growing concern in the United States and considered a future risk to public safety (Keogh, 2012). Mental health practitioners counseling youth with problem sexual behaviors use risk factor assessments to determine the appropriate interventions for effective results (Keogh, 2012). The two most popular risk assessment tools currently in use for youth with problem sexual behaviors are the Juvenile Sex Offender Risk Protocol (J-SOAP-11) (Prentky & Righthand, 2003), and the Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR) (Worling & Curwen, 2001). The J-SOAP-11 and ERASOR are functional in helping clinicians identify general risk factors such as, circumstances or conditions of their social environment, the context of the youth's development, past events related to sexual offending and antisocial behavior, and family relationships

associated with the client's sexual and criminal patterns and behaviors (Prentky & Righthand, 2003; Rich, 2011; Worling & Cowen, 2001). Although, both the J-SOAP-11 and the ERASOR are for clinical assessments, researchers Epperson, Ralston, Fowers, Dewitt, and Gore (2006) found that the Juvenile Sexual Offense Recidivism Risk Assessment Tool-11 (JSORRAT-11) is currently, the sole actuarial risk assessment in use for youth with problem sexual behaviors. The function of the JSORRAT-11 examines unchanging risk factors or conditions that increases risk and undesirable behaviors (Epperson et al., 2006). However, inconclusive studies (Grove & Meehl, 1996; Hansen & Thorton, 1999; Litwack, 2001) showed that a small scale of empirical evidence that question the validity of the instrument (Aebi, Plattner, Steinhauser, & Bessler, 2011). Przybylski (2014) mentioned that mental health practitioners are required by the ACA (2014), AMHCA (2010), APA (2010), and ATSA (2012) that treatment for youth with problem sexual behaviors are interventions that addresses the nature of the youth with problem sexual behaviors deviant sexual fantasies and sexual activities. Therefore, mental health practitioners are to use treatment models that match the intensity of the clients' needs and behaviors. As such, treatment model approaches that are most suitable for youth with problem sexual behaviors include Cognitive-Behavior Therapy (CBT), Cognitive-Behavioral Therapy and Relapse Prevention (CBT-RT), and Multi-Systemic Therapy (MST) (Przybylski, 2014). Furthermore, Przybylski (2014) contended that CBT, CBT-RT, and MST in conjunction for long-term behavior management for adolescent sexual offenders.

Cognitive-Behavior Therapy

Studies conducted by Dr. Aaron Beck (1993) revealed that individual's unconscious thoughts produce negative thinking regarding themselves, negative aspects of human life, and negative thoughts about the future (Beck, 1993). Beck pioneered the Cognitive-Behavior Therapy (CBT) approach as he helped clients recognize and analyze their negative thought and begin thinking more on what is real (Beck, 1993). As a result, CBT helped clients change their negative outlook about themselves and demonstrate behaviors that are appropriate and functional (Beck, 1993). Treatment approaches are determined based upon the youth with problem sexual behaviors antisocial behaviors (Etgar, 2012). CBT therapist specifically target issues such as, low self-esteem, issues in school and home, poor social skills, high suspicion, and anger and aggression towards others (Smith, Katslyannis & Ryan, 2011). In the past ten years, meta-analyses studies (Butler, Chapman, Foreman, & Beck, 2006) found that cognitive-behavior interventions are effective in treating youth with problem sexual behaviors (Prybylski, 2014). Mental health practitioners that use CBT are skilled and trained in CBT interventions and established a good counselor-client relationship that creates a comfortable and relaxed environment for the clients to discuss problems (Patterson, 2009). In the mental health profession, CBT has increased in popularity among mental health professionals because of principles that are adapted to diverse cultures and environments, simple perception, and cost effectiveness compared to traditional psychotherapy (Guadino, 2008). However, mental health practitioners are at risk of impairment using CBT without adequate knowledge, skills, and training (Myers, 2013).

Therefore, mental health practitioners are to have the appropriate qualifications and credentials to administer CBT and thereby prevent professional impairment (Myers, 2013).

Cognitive-Behavior Therapy and Relapse Prevention

Dopp, Borduim, and Brown (2015) examined the effectiveness of Cognitive-Behavior Therapy and Relapse Prevention (CBT-RP) for youth with problem sexual behaviors and found that CBT-RP interventions are successful to prevent further sexual deviant behaviors and recidivism. CBT-RP is a continuation of the CBT model that incorporates strategies such as self-management and supervision that prevent or restrict deviant behavior and recidivism (Becker & Kaplan, 1993). Studies conducted by McGarth, Cumming, Burchard, Zeoli, and Ellerby (2010) on CBT-RP showed that "80 percent of programs in therapeutic or community-based settings for youth sexual offenders focused on relapse prevention strategies that help clients in developing new interpersonal skills, anger management, awareness and sympathy for victims, and redirecting distorted thoughts and responses" (p. 9). McGarth et al., (2010) contended that interventions such as CBT-RP target the youth with problem sexual behaviors "criminogenic needs" (p.12) that assisted in reducing their desire for sexual offending. Cooper (2010) contended that, CBT, CBT-RP, and MST, are evidenced-based treatment approaches for youth with problem sexual behaviors and found the following:

> CBT, CBT-RP, and MST directly affect the indicators of interest, and one outcome is changed by 20%, d = .25 or more. The study design for CBT, CBT-RP, and MST used a convincing comparison group to identify program impacts,

> including studies that used random assignment or some quasi-experimental designs. Thus, the sample size of the evaluation exceeds 30 in both the treatment and comparison groups (p. 209).

McGarth et al. (2010) conducted a survey with 1,379 sexual treatment programs in the United States and reported that 86% of youth programs used CBT-RP as the treatment model approach because of interventions that decrease recidivism of sexual offending by restructuring cognitive thoughts (Corson, 2010). Mental health practitioners using CBT-RP strategies in counseling sessions must practice within the boundaries of their professional knowledge (ACA, 2014). Additionally, counselors must be competent in using skills that will ensure effective results and successful outcomes for the client's well-being (ACA, 2014; APA, 2010). As previously discussed, mental health practitioners are in danger of impairment when using therapeutic tools without possessing appropriate knowledge or understanding (ACA, 2014; AMCHA, 2010; APA, 2010). Impaired functioning interferes with mental health practitioner ability to be proficient and competent in providing quality care to clients or demonstrate professional behaviors that adhere to ethical codes and standards (ACA, 2014). Therefore, mental health practitioners are to maintain a level of competency in skills that promotes professional practice, and self-management care (ACA, 2014; APA, 2010).

Multi-Systemic Therapy

Multisystemic Therapy (MST) approaches are for youth with serious offending issues such as, child maltreatment, sexual victimization, and addiction abuse (Henggler & Borduin, 1990). Zajac, Randell, and Swenson (2015) described MST as family and community-based strategies that focus on externalizing problems associated with parental supervision, deviant peer association, home and school connections, and neighborhood crime rates. Additionally, MST are used in outpatient settings that when combined with CBT interventions assist to decrease youth's antisocial behaviors by incorporating family therapy, parental skills and training, and community-based resources (Dopp et al., 2015). MST goals are to remove barriers to treatment that include transportation, childcare, and timely access to treatment options (Zajac et al., 2015). Furthermore, mental health practitioners are actively involved with the families to build rapport and gain pertinent information between the client and family (Zajac et al., 2015). In a study by Bordium, Schaeffer, and Heiblum (2009) showed that MST approaches are effective in reducing recidivism with youth with problem sexual behaviors. More recently, Swenson and Letourneau (2011) contended that recidivism rates are lower for youth offenders given CBT combined with MST compared to youth offenders who only received. Thus, no single approach alone is as effective in reducing recidivism, but MST working in concert with CBT; produce effective and successful results with youth with problem sexual behaviors (Swenson & Letourneau, 2011; Bordium et al., 2009). MST approaches are evidenced-based and effective in reducing offending behavior among youth (Borduin et al., 2009; Przybylski, 2014; Swenson &

Letourneau, 2011). MST treatments are implemented using a team of two to four licensed and certified clinicians and involve intense interventions up to 60–100 hours of direct clinical servicers with the client, family members, and other members with the social ecology (Carrasco & Fox, 2012). Therefore, it is necessary for mental health practitioners to be skilled in administering MST to prevent impaired functioning that can affect their professional ethics and behavior and appropriate client care (Carrasco & Fox, 2012).

Summary and Conclusions

The literature review for this study found evidence that mental health practitioners should have specific clinical skill sets to be effective in diagnosis and treatment when counseling youth with problem sexual behaviors. Studies (Hayes, 2010; Lee, Cho, Kissisnger, & Ogle, 2010; Stovering, Hart, & Nelson, 2013) demonstrated that mental health practitioners need prerequisite classes and training to work with youth with problem sexual behaviors. Mental health practitioners who do not possess the appropriate clinical skills are at risk for impairment because of inadequate preparations to properly diagnose and treat youth with problem sexual behaviors, demanding work expectations, and disorganized documentation. As a result, mental health practitioners experience symptoms of impairment that prohibits quality client care and demonstrating ethical behavior and practice.

The literature examined the experiences of mental health practitioners working with youth with problem sexual behaviors. Additionally, topics emerged relevant to the subject including Ford and Blausten’s (2013) discussion on mental health practitioners’

challenges and controversies with counseling youth with problem sexual behaviors. Such challenges include occupational hazards, academic deficiency, ethical issues, and professional impairment.

Treatment models such as cognitive-behavior therapy, cognitive-behavior therapy and relapse prevention, and multi-systemic therapy are the most popular evidence-based treatment models for youth with problem sexual behaviors. (Dopp et al., 2015; McGarth et al., 2010; Przybylski,2014; Zajac et al., 2015).The literature reinforces that mental health practitioners are required to practice within their professional knowledge (ACA, 2014), and obtain and maintain the appropriate clinical skill sets to prevent impairment and quality client care (Calley, 2009; Lee et al., 2010; Nelson et al., 2002). A gap does exist in the literature because the information does not address the prerequisite skills for counselors who work with youth with problem sexual behaviors. Additionally, the literature does not address the counselor's self-awareness of preparedness for working with this population.

Chapter 3 describes transcendental phenomenology as the conceptual framework used for data collection in this research study.

Chapter 3: Research Method

Introduction

Chapter 3 provides a description of the conceptual framework of transcendental phenomenology and the strategies that addressed the lived experiences of counselors who work with youth with problem sexual behaviors. These components include the research design, a rationale for using this design, the sampling criterion for participants, a description of the research tool the process for collecting and analyzing data, the role of the researcher, and ethical procedures. Thus, the research helped to increase understanding of counselors lived experiences and illuminate the skills necessary when working with youth with problem sexual behaviors. Additionally, the information obtained could lead to better training programs so that counselors risk of impairment decreases. Greater understanding of the lived experiences of counselors highlighted the information needed to help counselor educators prepare counselors-in-training who choose to work with youth with problem sexual behaviors.

Research Design and Rationale

The research question sought to explore the lived experiences of mental health counselors who work with youth with problem sexual behaviors, and to learn about their perceptions of the requisite clinical skill sets for decreasing impairment and protecting them from impairment. Transcendental phenomenology specifically identifies a phenomenon as described by a human experience (Husserl, 1931).Transcendental phenomenology provides an accurate description of the phenomenon through the subjective eyes of the individual; it integrates the individual

experiences into a description of the phenomenon (Moustakas, 1994). Luft (2011) discussed that in transcendental phenomenology a person's awareness, consciousness, and understanding when analyzed reveal the essence of their experience. Transcendental phenomenology differs from hermeneutic phenomenology in that it does not focus on the researcher's explanation of the information common to hermeneutic phenomenology (van Manen, 2014). Additionally, the transcendental phenomenological approach allowed the investigation of experiences, perceptions, and beliefs of mental health practitioners who provide clinical services to youth with problem sexual behaviors (van Manen, 2014). I therefore used transcendental phenomenology to provide a rich description of mental health practitioners understanding about the clinical skill sets they need to decrease counselor impairment and to protect counselors from impairment in order to provide effective diagnosis and treatment for youth with problem sexual behaviors. Transcendental phenomenology was appropriate for this study because it (a) provided an accurate description of the participants' experiences with youth with problem sexual behaviors and (b) answered the research question.

Role and Positionality of the Researcher

As the researcher in this study, I carefully considered all aspects of research throughout the course of the research design. I addressed the research question, and ensured participants were safe guarded from exposure, injury, or harm. In qualitative research, the researcher is the primary instrument of collecting and analyzing data (Patton, 2015; Denzin, 2011). Obtaining data through human participation warrants the

genuineness of detailed description of the participants lived experiences with youth with problem sexual behaviors.

Baker and Pifer (2014) described positionality as the reflexivity and position of the researcher in making decisions quickly and confidently, and cognizant of social factors that influences the researcher's perception of the world (Throne, 2012). As the researcher, I sought to study the topic due to prior experience as a counselor working with youth with problem sexual behaviors, and the frustration I felt in being unprepared to provide appropriate clinical services. As such, my position is to take preventive measures to ensure that personal bias does not interfere or influence the study by personal identification. I used bracketing as a preventive measure to reduce bias so as, to maintain objectivity due to prior experience counseling youth with problem sexual behaviors (Creswell, 2013). Bracketing is the process by which the researcher acknowledges their past experience, attitude, and beliefs, but attempts to set them aside for the duration of the study to see the phenomena of interest in a different way (Tufford & Newman, 2012). Therefore, bracketing prevented a pre-research bias, which limited conclusions to the research data obtained from the participants (Creswell, 2015). Furthermore, I made personal observations throughout the study and took any concerns related to my own bias and experience with the population to my dissertation chair and/or methodologist. I continued to monitor the research process so that ethical guidelines follow the moral principles and standards for professional conduct (ACA, 2015).

Methodology

Participant Selection

The participants in this study were a criterion sample of eight to ten licensed professional clinical counselors (LPCCs) from one city in Ohio. I contacted a regional director of a mental health agency to obtain authorization to conduct the study with selected LPCCs. Receipt of authorization facilitated as an electronic invitation with information on the study to mental health agencies with LPCCs residing in a city in Ohio. The criterion sampling for participant selection was the following: Each participant must have one to three years of counseling experience with youth with problem sexual behaviors. Studies conducted by Keim, Olguim, Marley, and Thieman (2008) showed that one to three years is the timeframe mental health practitioners are at high risk for impairment. Furthermore, the ACA (2014) contended that mental health practitioners with limited clinical skill sets unintentionally fail to recognize indicators of professional impairment and neglect the welfare of the client. Additionally, LPCCs have experience with situations, conditions, and events with the phenomenon to obtain their perspectives working with youth with problem sexual behaviors. I recruited LPCCs from diverse backgrounds, cultures, and ethnicities so that the study's findings are fair and unbiased. Participants were age appropriate for informed consent and had education and intelligence to participate in the study.

Procedures for Recruitment

The selection of a sample size for a research study was determined by contributing factors that included the research question, resources that are accessible,

and procedures for the data collection and analysis (Patton, 2015). Creswell (2013) proposed that a suitable sample size for a phenomenological approach consists of three to ten subjects for receiving tangible information for the researcher to understand the participant's experiences. Therefore, the sample size for this study was eight to ten participants. I used criterion sampling to identify and selecting participants who have knowledge on the topic and could describe the impact of their experiences (Creswell & Plano Clark, 2011; Patton, 2015). Saturation and sample size have a correlation for centering the research and determining the number of participants for the study (Creswell, 2013; Gutterman, 2015; Mason, 2010; Patton, 2015). Therefore, saturation and sample size share a relationship that determines the caliber of the depth and the validity of the data in phenomenological research (Kerr, 2010; Rubin & Rubin, 2012).

Instrumentation

Research instrumentation systematically collects data for a research study (Rimando et al., 2015). Researchers using a qualitative approach utilize a variety of sources to obtain data in the form of interviews, and focus groups (Creswell, 2013; Denzin & Lincoln, 2011; Rimando et al., 2015). In this study, I used a phenomenological approach to collect data through instrumentation of in-person interviews, transcription, and observation.

Interviews

Interviewing is the process to obtain information through verbal communication (Edwards & Holland, 2013). In this study, I used interviewing to collect data on the experiences, perceptions, and beliefs of the participants' counseling youth with problem

sexual behaviors, and to answer the research question, (Creswell, 2013). For a qualitative interview, the researcher becomes the instrument by recognizing any conceptions that prevent understanding the phenomenon under study (Patton, 2015). In this study, I used a semistructured interview (See Appendix A) because of flexibility in the type of questions that specifically cover the topic, and how participants choose to respond (Rubin & Rubin, 2012). The interviews included one 60-minute audio-recorded in-person interview. As part of the triangulation process, I transcribed the interviews, and utilized member checking to ensure trustworthiness and quality of the data (Creswell, 2013).

Transcription

In a qualitative study, transcription is a process of translating audio-recorded interviews from spoken text to written form of analysis (Sutton & Austin, 2015). Skukauskaite (2014) commented that transcribing recorded interviews is essential for the researcher in making decisions that impacts what is comprehend from the data. Transcribing data helps the researcher obtain greater understanding of the participant's experience of the phenomenon. I transcribed the interviews for accuracy of the generated meanings and perceptions shared by participant during the interviews (Sutton & Austin, 2015).

Data Analysis Plan

Appropriate for a phenomenological study, I used data analysis techniques for combing textual descriptions that disclosed the meaning of the phenomenon under investigation (Patton, 2015; Sutton & Austin, 2015). I analyzed the data through

horizontialzation, cluster of meanings, and coding for emergent themes (Patton, 2015; Sutton & Austin, 2015). In accordance with Moustakas (1994), horizontialzation is the first step to analyzing data. Therefore, I was amenable to every statement of the participants' experience and allowed each statement to share similar value (Moustakas, 1994). Moustakas (1994) discussed that horizontialzation is associated to bracketing whereas the researcher must be careful not to demonstrate behavior that is biased when analyzing each statement. Clusters of meaning, creates "core themes of the experience" of the phenomenon (Moustakas, 1994, p. 121). I used clusters of meaning to identify units significant to the topic, and group these units of meaning together (Creswell, 2015; Eddles-Hirsch, 2015; Moustakas, 1994). By analyzing the clusters of meaning, primary themes are conclusive in showing the essence of the meanings (Eddles-Hirsch, 2015). I used coding to identify word similarities in the text and attach labels for indexing. Themes that emerge from coding are classifications and aspects of the participants' descriptions of their experiences and perceptions that are applicable to the research question (Sutton & Austin, 2015). Researchers spend considerable time and effort analyzing data from transcripts, field notes, and audio-recordings (Zamawe, 2015). I used NVivo, a Computer Assisted Qualitative Data Software (CAQDAS) that aided in organization, categorization, sorting, and storing of data (Bazeley, 2007).

Issues of Trustworthiness

Rigor or quality of data ensures the trustworthiness of its findings (Miles, Huberman, & Saldano, 2014). In a qualitative study, the intent of trustworthiness supports the value and soundness of the study's findings by the accuracy of detailed

data (Creswell, 2013; Miles et al., 2014). Anney (2014) proposed the reliability of trustworthiness in a study's findings establish four criteria including, credibility, transferability, dependability, and confirmability.

Credibility

Credibility reflects the truthfulness of the study's findings from the data collected from interviews, notes, and recordings from participants in the study (Anney, 2014). In this study, I established credibility through interviewing and audio-recordings to elicit descriptive information from the participants on the phenomenon being investigated (Creswell, 2015, 2013). Triangulation through multiple data sources helped determine the accuracy of the data revealed by the participants (Creswell, 2013; Patton, 2015). Participants validated the credibility of the study's results (Patton, 2015).

Transferability

Authors Anney (2014) and Trochim (2006) defined the term transferability is the level by which research can be transferred to other contexts that construct an explanation for similarities in the data source. Lincoln and Guba (1985) stated, "by describing a phenomenon in sufficient detail, one can begin to evaluate the extent to which the conclusions drawn are transferable to other times, settings, situations, and people" (p. 306). In this study, to accomplish transferability, I used notes from interviews, and conversations recorded with participants to provide a "thick description" of the phenomenon (Geetz, 1973; Holloway & Wheeler, 2010; Ryle, 1949). Holloway and Wheeler (2010) described thick description as similarities among

people that characterize the patterns of their behavior impacted by cultural and social relationships and clarify its meaning.

Dependability

Dependability tests consistency and stability of data collection procedures across time, conditions, and cultures (Miles et al., 2014). I used audit trails for maintaining records how the research conducted and validate the truthfulness of the study's findings (Miles et al., 2014). Additionally, audit trails provided evidence that the source data have gone through examination, reduction, and synthesis (Miles et al., 2014). Furthermore, audit trails are resourceful assisting other professionals in the field to find specific source texts for meaning and understanding. Thus, audit trails were necessary for this study as a blue print to researchers for future studies.

Confirmability

Confirmability in research is the acceptance and accuracy of the study's results reflected by the perspectives of the participants (Anney, 2014). The most accepted strategies of confirmability for research included, audit trails and reflexivity. As discussed previously, audit trails are procedural records of the study (Miles et al., 2014). In a qualitative study, reflexivity constitutes what the researcher knows about oneself, the participants in the study, and preconceived bias about the research subject (Creswell, 2013; Malterud, 2001). To neutralize bias that might occur in this study because of prior experience as a mental health practitioner counseling youth with problem sexual behaviors, I used bracketing as a preventive measure to reduce bias and remain objective (Creswell, 2013). Marshall and Rossman (2014) discussed that

bracketing requires the researcher to set aside personal belief about the phenomenon under investigation and seeing differently without judgment or bias. Part of the informed consent is the record keeping and storage of the data. Information from the data management program, NVivo, is stored in a locked file cabinet in my office for a minimum of five years (Bazeley, 2007; Creswell, 2013). In conclusion, I sought trustworthiness to ensure an in-depth analysis of data that validated the truthfulness from participants' experience of the phenomenon.

Ethical Procedures

In a qualitative study, researchers encounter challenging situations that can lead to ethical concerns (Creswell, 2013). The ACA (2014) contended that researchers demonstrate ethical practice while conducting research by protecting and respecting the rights of participants and substantiate professional identity that influences their understanding as a mental health practitioner in the field. Sanjari, Bahramnezhad, Fomani, Shoghi, and Chiraghi (2014) discussed the most pertinent ethical issues for researchers are, informed consent, and confidentiality. Researchers are to incorporate informed consent so that participants are informed of the different aspects of the research including, the significance of the study, role of the researcher, their role as a participant, the accomplishment hope to achieve, and how will publication of the study's results be publically viewed (Sanjari et al., 2014). The Internal Review Board (IRB) by Walden University approved this study with the designation number of 07-27-17-0308470. I used informed consent so that participants understand the benefits and risks of the study, and understand their participation is voluntary and they can

discontinue at any time (Creswell, 2013; Sanjari et al., 2014). Confidentiality is the term used to define the duty of the researcher to decrease any threats that expose the anonymity of participants (Sanjari et al., 2014). Confidentiality is a precaution to provide a level of anonymity for participants that safeguard their personal information (Sanjari et al., 2014). I used confidentiality through assigning participants a pseudonym and not their name. Additionally, procedures using NVivo was discussed with participants to ensure that all written and recorded notes are stored in a locked file cabinet in my office for a minimum of five years (Bazeley, 2007; Creswell, 2013).

Summary

In Chapter 3, I discussed the research methods in completing the study. The major elements for Chapter 3, included, the research strategy for answering the research question, and data collection procedures and analysis. A description and explanation of the data procedures, as well as, the role of the researcher, and sampling criterion for selecting participants for the study will occur. Chapter 3 concluded with a detailed description of the data analysis plan, and the strategies to show the study’s trustworthiness and addressed ethical issues.

In Chapter 4, I discuss the study’s findings from the data obtained from participants’ interviews and recorded conversations.

Chapter 4: Research Findings

Introduction

The purpose of this phenomenological research study was to understand the lived experiences of counselors who work with youth with problem sexual behaviors. The research question what are the lived experiences of counselors who work with problem sexual behaviors? The data that resulted from the guiding question revealed the lack of skills and training and unpreparedness of counselors to work with this population. During the interview, participants described their experiences working with youth with problem sexual behaviors this conversation generated further understanding of the topic. The findings in this chapter are the results of the analysis of the following components: setting, demographics, data collection, data analysis, trustworthiness of data, and data results.

Setting

The setting for the interview with participants took place in the two following locations: (a) Six of the interviews took place in the participant's place of employment, and (b) At their request, two interviews were at the Columbus Metropolitan Library in a private study room.

Demographics

The participants in this study consisted of 8 licensed professional clinical counselors in Ohio. Six of the participants were female and two were male; their ages ranged from 22 to 45; four were White, three were Black, and one was multiracial. All eight participants had 1–3 years of experience as a counselor. Additionally, the two

male participants had previous experience as a probation working with high-risk youth with sexual and behavior problems officer at a juvenile detention center. All the participants described themselves as having an educational background in psychology or community counseling as a part of their current position as a counselor. The participants provided detailed descriptions on their experiences, which contributed to the emergence of three themes.

Data Collection

To collect data, I interviewed each of the eight participants in person for one 60- minute, digitally recorded session. Six of the interviews were at the participant's place of employment and two held at the local public library in a private study room., There is no recorded evidence of personal or organizational condition such as employment or personal duress that could influence the results of the study. I manually transcribed the information and used NVivo to help highlight similarities found in words, phrases, and patterns.

Data Analysis

For this phenomenological study, I analyzed the data using horizontialzation, clusters of meaning, and coding. Patton (2015) discussed that in qualitative studies data analysis techniques using horizontialzation, clusters of meaning, and coding combine textual descriptions that reveal the meaning of the phenomenon. Moustakas (1994) discussed that horizontialzation is the first step in analyzing data and connected to bracketing whereas the researcher must be careful to demonstrate behavior that is unbiased when analyzing data information. I used horizontialzation by demonstrating

behavior that showed no prejudice, judgement, or impartiality when analyzing the responses from the participants (Moustakas, 1994).

Creswell (2015) described clusters of meaning as units such as, words, phrases, and patterns that are significant to the topic, and group these units together. In this study, I used clusters of meaning to identify the key themes that are conclusive in showing the intrinsic nature of the themes meanings. The clusters were determined by the number of times of words, phrases, and patterns as determined by the similarities in the participants' statements. The process of coding categorized the similarities found in the words, phrases, and patterns to develop themes found in the data (Sutton & Austin, 2015). I used coding for identification of the participants descriptions of their lived experiences of the phenomenon. I used NVivo to help organize, categorize, sort, and store data. Three themes that emerged from the data included: (1) personal responsibility, (2) self-care, and (3) training.

Theme 1: Personal Responsibility

During the interview sessions, four of the participants acknowledged experiencing emotionally intense feelings and their responsibility associated to coping with the challenges working with youth with problem sexual behaviors. The most dominant emotions included frustration, anger and fear. For example, Participant A stated, "When a youth refuses to cooperate and acts out, I feel very frustrated at that youth." Participant C discussed frustration towards the juvenile system and stated, "Most of my frustration is not directed toward the young men, but to the juvenile systems. Working with so many different agencies you see different views, and this becomes more

challenging to get everyone on the same page." Participant D associated feeling frustrated when the youth purposely exhibit negative behavior with their peers, and stated, "My frustration is when a youth purposely creates a negative situation that sets off a bad chain reaction with the other youth." Participant F described their frustration when youth regress and not progress, and stated, "When we work with our clients you're supposed to meet the client where they're at, but that doesn't always work out and it's very frustrating and makes me angry because you hate to see the client move backwards and not forward."

Three of the participants discussed fear as dominant emotions that influenced their ability to perform on a professional level. For example, Participant B feared for younger male family members and stated, "I'm always asking my two younger nephews did anyone hurt you today? There's no reason it's just, you now look at the world and people differently knowing that stuff." Participant E discussed fear by allowing personal feelings to influence their work responsibilities, and stated, "Whenever I'm working with a kid I want to make sure that I'm saying things and doing things that are influencing him to be better, but I fear that I'm not doing enough or maybe I don't understand enough to help the kid do better." Participant G discussed fear as a dominant emotion because of a prior work experience at a juvenile detention center and a youth committing suicide while on duty and said, "Whenever a kid talks about suicide it concerns and scares me because I'm afraid something is going to happen, and I will be blamed for it." Additionally, Participant D discussed occasionally responding negatively and angry to youth and stated, "I am angry at times when the youth

understands they have done things that are criminal and inappropriate, but they say they can do what they want without any consequences. I just want to tell them that they need to get their shit together." The clusters in theme one included: (a) dominant emotions, (b) influential emotions.

Cluster 1.1: Dominant emotions. All the participants identified feeling frustrated and challenged when the treatment plan for the client is ineffective. Two of the participants were specific in describing their reactions when frustrated. For example, Participant A stated, "Sometimes it is difficult to stick with the treatment plan for kids when they are acting out, and this creates tension, and frustration from the kid and myself." Participant D had a similar reaction to frustration and stated, "When I have challenges with these youth, I spend a lot of time on the phone with my mentor and colleagues barking out my frustration. I know I got to be straightforward with the kids, but sometimes I just want to say, sit your ass down, and get your shit together." Three of the participants recalled feelings of anger and fear as dominant emotions in their reactions. For example, Participant G stated, "I had a situation when I worked as the probation officer in the juvenile detention center where the youth committed suicide right when I went off duty. The thing is that I had just reported this to the lead supervisor that the youth is watch because he is depressed. Nothing was done, and I was blamed for not reporting it earlier. Now, whenever a kid talks about suicide it concerns me, because I'm afraid something is going to happen, and I will be blamed for it and that makes me angry." Participant H stated, "Some of the negative things you hear and see from these kids makes you question society and I am afraid for our future

generations." Participant F discussed feeling anger and stated, "I wonder just how much is helping because of their environment or situation. I think it's like a cycle that when we work with our clients you're supposed to meet the client where they're at, but that doesn't always work out and you see the kid move backwards and not forward, and this makes me angry."

Cluster 1.2: Influential emotions. All the participants reported emotions that influenced their lives and affected their personal and social relationships. Three of the participants recalled the impact with family members. For example, Participant H stated, "I go home and question my thirteen- year- old daughter about her friends, school, who she is around. Sometimes it can make you a little paranoid. My daughter is looking at me like mommy's had a bad day and taking it out on me. At home I go to my quiet space and my husband and children know that I had a rough day and need some quiet time." Additionally, Participant B was deeply concerned how emotions have influenced her communication with her family members and stated, "I have two nephews and I'm always asking them did anyone hurt you today. There's no reason it's just you now look at the world differently knowing that stuff." Participant A for example, recalled experiencing days that influenced her behavior at home and stated, "I go home and take it out on my partner. I mean I went home feeling sad, frustrated and a little angry and I took these feelings home with me and was not pleasant to be around." Two of the participants discussed emotions that influenced their social and worldview associated with working with youth with problem sexual behaviors and organizations that provides services to this population. For example, Participant H stated, "Youth are

being exploited through social media on sex, and they use this as a gateway to do what they want sexually without any consequences. As a counselor, I often feel that the world is overlooking the impact it has on these youth." Participant C discussed the negative impact working with various organizations that work with youth with problem sexual behaviors and stated, "WOW, I can say the negative impactful experience is not directed to the young men, but to the systems. Working with so many different agencies you see different views and this becomes more challenging to get everyone on the same page." Therefore, the participants recognized that influential emotions such as anger and fear occur when working with youth with problem sexual behaviors.

Theme 2: Self - Care

The participants acknowledged that challenges and struggles exist on the job, and how they choose to respond varies. All the participants discussed the importance of having a self-care plan to prevent impairment. In accordance with ACA (2014), mental health counselors are to monitor their mental and emotional well-being to be effective and successful counseling clients and implement self-care strategies for professional stability. Authors Carter and Barnett (2014) asserted that counselors that develop a professional self-care plan by seeking out advice from colleagues with more experience, and regularly attend professional development workshops and training would prevent or decrease impairment. All the participants agreed that self-care strategies are necessary to prevent impairment. Clusters in theme two included; (a) self-care, (b) preventing impairment.

Cluster 2.1: Self-Care Strategies. Six of the participants shared their experiences on using self-care methods to decrease negative feelings and behavior when they encountered challenges working with youth with problem sexual behaviors. For example, Participant C stated, “I feel self-care is absolutely needed in the profession. As a therapist, I practice living a healthy lifestyle and take mental health days from work when I need it.” Additionally, Participant E stated, “I have a mission of self-care and use relaxation techniques daily to stay motivated when I have to cope with some of the day to day work challenges.” Participant A discussed two important self- care components to help her cope with work strategies and stated, “Self-care is important, and I like using different types of relaxation techniques like yoga and walking and talking to my colleagues for support.” Participant D defined self-care is time away and stated, “It is most important for me to have me time and I go camping for the weekend and turn off my phone and forget everything. I also manage to indulge in massages every once in a while, and I do yoga.” Participant F addressed awareness as their approach to self-care and stated, “After a day, I’m trying to process what I need to do the next time I see the client. I think about what I could have changed or done better.” Lastly, Participant G discussed exercise as their self-care strategy and stated, “For me, self-care is working out, long bike rides, or long walks, this helps me to relax.” The participants were unified and communicated the message that self-care is an important component for professional longevity. Therefore, counselors that implement a self-care strategy plan have more resilience working with youth with problem sexual behaviors.

Cluster 2.2: Preventing impairment. All the participants eagerly discussed their experiences on negative influences that affected their professional functioning. Five of the participants remembered experiencing some of the characteristics associated with impairment. For example, Participant D stated, “When I have challenges and it affects the way I work with my client, I spend a lot of time praying. I am a very religious person and my belief and church helps me to stay focused and not feel overwhelmed. I also have a mentor that I work with and I spend a lot of time on the phone barking out my frustration.” Participant F stated, “Awareness and a lot of critical thinking, helps me stay on track when I’m not functioning as a counselor.” Participant C stated, “She is a work in progress, because there are times after a hard session with the client that I feel drained and nothing else to give. I realize that’s not a good place to be professionally, but it happens too often and that’s when you have to step back and talk to colleagues or supervisor about your feelings before it gets out of control.” Participant E stated, “Impairment is interesting and a little hard for me to verbalize, but there are occasions when I had some difficult sessions I felt like I was completely lost and everything was going to fall apart, and that is being impaired. When I feel this way, I have to take a few mental health days just to reflect and clear my head.” Participant B discussed a strong team help to prevent impairment and stated, “The biggest thing we have is a strong team so we talk a lot and process a lot. We are all in the same boat and know what we’re going through and that’s really helpful and I am able to let things go.” All the participants discussed the seriousness of counselors who are impaired and as a result incompetent to function professionally and the potential to harm clients.

Theme 3: Training

All the participants are professionals who have been educated in theoretical knowledge, and general skill sets in mental health. The data uncovered that participants academically lacked particular prerequisite classes and training that specifically targeted the risks and needs tailored to effectively treat youth with problem sexual behaviors. Stovering, Nelson, and Hart (2013) contended that counselors who work with youth sexual offenders should have the appropriate level of education, expertise, and instruction for effective counseling and treatment. There was a common exchange in the participant responses that academically they were unprepared to understand the specific needs of youth with problem sexual behaviors. Chassman, Kotter, and Madison (2010) discussed issues in academic counseling programs in excluding curriculum that address the clinical skills needed to work with youth with problem sexual behaviors. Additionally, Nelson et al., (2002) contended that academic and mental health programs should identify the specific clinical skills necessary for new and counselors-in-training who choose to work with youth with problem sexual behaviors. The participants acknowledged that they learned the fundamental principles of theory in their academic institutions but lacked in implementing practical application or hands-on-training in internship. Clusters in theme three included; (a) academic institutions, (b) hands-on-training.

Cluster 3.1: Lack of Academic Preparation. All the participants reflected upon their academic program and discussed feeling unprepared to work with youth with problem sexual behaviors. For example, Participant A stated, “Academically, in school

I learned about theories which is good, but I have learned more about this population through internship where I had face-to-face contact with the kids." Participant B had a similar response relating to her academic institution and stated, "In my Master's program they showed video's where kids were cooperative and sitting in a group and all they wanted was counseling, in school I liked that I learned about theories but that was all it was." Participant C felt her academic program was scientific based but lacked to provide understanding in working with specific populations, and stated, "My academic program did a good job in preparing me as a counselor, but not in working with certain populations, it was more general psychology." Participant D responded strongly that academically she was unprepared and stated, "I don't feel like I was prepared at all, what I learned about these kids, I didn't learn in school." While, Participant E thought it interesting that in school he felt like he had a good grasp of things and prepared, but stated, "When I graduated school and landed a job working with these kids, I felt like I didn't learn anything, and I really didn't understand what these kids needed." Participant F stated, "Academically, no, I didn't get a lot of information on working with this population." Additionally, Participant G had a similar response and stated, "I think from looking at the school aspect I don't think I was prepared as well as I should have been because you know, reading about things is different from being hands-on experience." Lastly, Participant H was unsure if academic institutions could properly prepare you to work with youth with problem sexual behaviors and stated, "Academically, I was not prepared, institutions need to look at the curriculum on what is being focused on with youth, and alternatives that are more realistic."

Cluster 3.2: Hands-on-training. The responses from six of the participants revealed that hands-on-training was crucial to understanding the most effective clinical models and skills to use with youth with problem sexual behaviors. For example, Participant A stated, “I have learned more about this population by hands-on-training and this gave me a better understanding in how to work with the kids.” Participant B concurred and stated, “My school program would have been more instrumental with more hands-on-experience. I learned the most during my internship than from my professors.” Participant D indicated that internship played a vital part of learning about this population and stated, “Internship was a big part of what I learned and continue to learn with these kids.” Additionally, Participant E stated, “More hands-on experience is needed and I didn’t really receive this until I was in the internship, hands-on-training is the best teacher.” Participant G expressed concern for counselors-in-training who lack practical training and stated, “New counselors coming into this field need to know more about realistic things rather than what you read in a book, and hands-on-training can help them be better prepared to work with this population.” Finally, Participant H stated, “As counselors we are in line to help youth move forward and there are many things not being done right in terms of youth with sexual behavior problems. Counselors who want to work with this population need hands-on-training to understand what the client needs.” All of the participants were elaborate on their lived experiences working with youth with problem sexual behaviors, and their responses contributed to the three themes that developed for greater insight and understanding on the phenomenon.

Evidence of Trustworthiness

All the participant's responses were credible based on triangulation of the accuracy of the data sources. The study's findings validated the trustworthiness of the data obtained from the participants that determined the credibility, transferability, dependability, and confirmability of the study's results. In this study, the credibility of the data was from the audio-recorded interviews and notes with the participants. All the participants engaged in one 60-minute interview and answered questions that pertained to their experiences working with youth with problem sexual behaviors. There was no adjustment needed to the credibility strategies. Transferability occurs through the transcribed interviews from the participants. The interviews characterized the similarities of patterns and behaviors among the participants. There was no adjustment needed to the transferability strategies in this study.

The dependability of the data over time, conditions, and situations secured and validated the truthfulness of the findings. In this study, audit trails provided evidence that data analysis occurred, and can be a resource for other professionals to use for future studies on the topic. There were no adjustments to the dependability strategies. The confirmability of the study results was accepted and accurate as reflected by the participant's perspectives. I used bracketing to prevent any personal belief, judgement, or bias. There was no adjustment needed to maintain the consistency strategies in this study.

Results of the Findings

The purpose of this qualitative phenomenological research study was to understand the lived experiences of counselors who work with youth with problem sexual behaviors. The research findings through transcendental phenomenology increased understanding of these experiences and illuminate the prerequisite skills, necessary when working with this population. Initially, all the participants responded that they chose to work with this population because they had a desire to help these youth and assist them in making better life choices. All participants chose to work with youth with problem sexual behaviors. Counselors come in with high hopes and are optimistic seeking to help high-risk youth. For example, Participant A stated, “I always loved working with kids, and I’m a people person. My interest has been in psychology and mental health for many years, but mainly I just want to help youth with sexual behavior problems.” Most of the participants strongly responded that their positive experience was in being instrumental in helping change the direction of the kids that come to the program. For example, Participant F stated, “I get phone calls from kids who graduated from the program, and they want to come and talk to the current kids in the program how they can change and do good.” When the client begins to take responsibility for their actions this is a positive experience. As stated by Participant C stated, “When a youth is learning and understands good/bad, right/wrong this is a positive direction.” Through a literature review, I found that counselors who work with sexually aggressive youth should focus on their strengths and positive attributes as a

point of rehabilitation, and achieve personal, interpersonal, and social success (Print, 2013).

All the participants responded that self-care is necessary and implemented for maintaining healthy personal and professional relationships. I found literature that counselors should develop a professional self-care plan to manage occupational stressors and maintain professionalism. A good self-care plan includes; weekly meetings with a supervisor or staff with more expertise and experience for advice, and regularly attending professional development workshops and trainings (Carter & Barnett, 2014). Most of the participants discussed the diversity in self-care techniques they use, but they all agree that utilizing self-care practices is important in the profession. The question of self-care received a tremendous response from the participants for example, Participant C stated, "Self-care is necessary and should be implemented frequently to refresh your mind", and another participant described, "Self-care is absolutely needed in the profession. I like to get away where I am able to turn off my phone and forget everything. I do yoga where I stretch and meditate." Additionally, Participant B stated, "Self-care is most important in the profession. I like relaxation techniques and getting together with other staff for support." All the participants utilized some form of self-care for maintaining a healthy professional and personal balance. For example, Participant G stated, "The biggest thing we have at this agency is a strong team, so we talk and process a lot. We are all in the same boat and know what we're going through and that's really helpful so when I go home I am able to let it go." Further responses from the participants discussed the importance of self-care strategies

and awareness to prevent impairment. For example, Participant D stated, "Self-care is very important and I like using relaxation techniques like yoga, and talking to other therapist to maintain my peace of mind." I found through the literature review that self-care strategies reduce and/or prevents counselor impairment. More specifically, Barnett and Sarnel (2003) asserted that self-care strategies promote the counselor's good health and happiness. Furthermore, Brennan (2013) discussed that counselors need to monitor their mental and emotional well-being to be effective counseling clients.

The literature review validated that challenges occur for counselors who work with youth with problem sexual behaviors. I found through literature that counselors who work with youth sexual abusers encounter challenges through in-person interactions and confrontational situations. As a result, counselors experienced emotional distress associated with stress, discouragement, and burnout (Linnerooth, Mrdjenovich, & Moore, 2011). Additionally, Newell and MacNeil (2011) noted that counselors who work with at-risk youth experience stressors and conditions that affect the counselor's overall well-being and quality of life.

Although the participants felt prepared to work with youth for general counseling, whereas, working with youth with problem sexual behaviors they lacked specific clinical skill sets. I found a literature that supported the necessity of having appropriate prerequisite skills and training to work with youth with problem sexual behaviors. Stovering, Nelson, and Hart (2013) argued that counselors working with youth with problem sexual behaviors lack the appropriate education, expertise, and instruction to be effective in providing clinical services for their clients. All participants

strongly responded that they were not prepared academically to work with youth with problem sexual behaviors. Academically, they felt their school program was successful in teaching on various theories, but the institution failed in demonstrating a clear understanding on the clinical skills needed to be effective working with this population. The participants shared their experiences with hands-on-training that provided more understanding how to work with youth with problem sexual behaviors. Most participants' responses were similar that they were unprepared to work with youth with problem sexual behaviors. For example, Participant B stated, "In school I learned about theories which is good, but I have learned more about this population by hands-on-training. This gave me a better understanding in how to work with these kids." Additionally, Participant C stated, "I learned about theories in school, but I learned the most about these kids during my internship and from the people here at The Village Network."

For this phenomenological study, the findings confirmed the literature that counselors are not prepared to work with youth with problem sexual behaviors because they lack the appropriate clinical skill sets. The literature review revealed that a problem exists in academia counseling programs that do not provide curriculum that specifically aims at the needs of youth with problem sexual behaviors (Kotter & Madison, 2010). Furthermore, Nelson et al., (2002) indicated that academic institutions and mental health organizations must recognize the need in preparing current and future counselors who choose to work with youth sexual abusers to have clinical skill sets for understanding in administering proper diagnosis and treatment.

The interview questions (See Appendix A) did not specifically ask participants about the treatment approaches they use for youth with sexually behavior problems however; I found literature that supports specific treatment model approaches used with youth with problem sexual behaviors that have positive results. Przyblski (2014) discussed the most popular and effective treatment models for youth with problem sexual behaviors include, Cognitive-Behavior Therapy (CBT), Cognitive-Behavioral Therapy and Relapse Prevention (CBT-RP), and Multi-Systemic Therapy (MST). Dr. Aaron Beck (1993) introduced Cognitive-Behavior Therapy (CBT) that helped clients change their self-negative outlook to behaviors that are socially appropriate and functional. Dopp, Borduim, and Brown (2015) found that combining Cognitive-Behavior Therapy and Cognitive-Behavioral Therapy and Relapse strategies such as, self-management and supervision prevented clients from demonstrating deviant behavior and recidivism. Zajac, Randell, and Swenson (2015) discussed that Multi-Systmeic Therapy focusses on family and community-based techniques that incorporates parental supervision, differential peer associations, home and school connections, and neighborhood crime rates. In this study, the results of the finding have sustained in the literature review, and upon further review of the literature and findings, I found no discrepancies are present. Additionally, I did not encounter any non-confirming data.

Summary

In Chapter 4, I conducted semi- structured in-person audio-recorded interviews that answered the research question. All the participants were actively engaged in the interviews and provided responses that were genuine in their accounts on their lived experiences working with youth with problem sexual behaviors. The data collected answered questions that included, the challenges on the job and the impact that associate to feelings of frustration, anger, and fear. Additionally, responses from participants provided intrinsic value on the necessity for self-care in the profession, and strategies for preventing impairment. Chapter 4 concluded with discussing academic preparation and practical training as a prerequisite for new counselors who choose to work with youth with problem sexual behaviors.

To this end, Chapter 5 discussed the interpretation of the study’s findings, limitations on the trustworthiness of the study, future research recommendations, implications for positive social change, and the study’s conclusions.

Chapter 5: Discussion, Recommendations, and Conclusion

Introduction

The purpose of this study was to understand the lived experiences of counselors who provide clinical services work to youth with problem sexual behaviors. I conducted research using semistructured, in-person interviews with eight counselors. The responses from the participants provided a more concise understanding of their subjective experience as counselors working with youth with sexual behavior problems. The detailed descriptions of the participants' account of their experiences contribute to the understanding and meaning as ascribed to impairment. The key findings in this study are as follows: Counselors working with youth with problem sexual behaviors lacked requisite skills to work with this population; to cope they used self-care strategies. I discuss the implications of these findings with respect to the literature review and the theoretical framework. The chapter concludes with recommendations for future research on the topic.

Interpretation of the Findings

In concordance with the literature review, the findings confirmed that counselors working with youth with problem sexual behaviors encountered challenges such as emotional issues, occupational hazards, academic deficiencies, and professional impairment. The words, *frustration, self-care, impairment, unprepared,* and *hands-on-training* were frequently expressed by the participants during the interviews. These words are significant because they reflected the themes in this study. The emotional challenges contributed to the counselor's inability to provide appropriate clinical

services to youth with problem sexual behaviors. Participants' repeatedly mentioned frustration, anger, and fear when they described their emotional state when working with youth with problem sexual behaviors. Chassman, Kottler, and Madison (2010) found that mental health counselors with minimal knowledge and clinical skills to counsel youth sexual abusers are prone to stress, frustration, discouragement, and impairment. Stovering, Nelson, and Hart (2013) postulated that the literature barely addresses the impact on counselors working with youth sexual abusers as well as the negative attitudes of counselors working with this group. Moreover, counselors who counsel youth with problem sexual behaviors develop attitudes that negatively influence their perceptions and thinking in diagnosis and treatment (Hogue, 1993; Jones, 2016; Nelson et al., 2002; Stovering et al., 2013; Ward, Connally, McCormack, & Hudson, 1996).

In this study, the participants discussed the challenges they encountered working with youth with problem sexual behaviors. Counselors' who work with this population risk exposure to clients who have had traumatic experiences that affects their ability to function professionally. According to the literature, counselors who provided counseling services to youth with problem sexual behaviors faced work challenges through intense face-to-face interaction and confrontation. As a result, counselors were incapable of functioning professionally because of stress reactions, discouragement, and burnout (Linnerooth, Mrdjenovich, & Moore, 2011).Newell and McNeil (2011) found that counselors working with high risks youth are even exposed to stressors and conditions that affect their well-being and quality of life. In this study, participants

acknowledged that there were indeed occupational hazards. Through the literature review, I found that counselors consistently exposed to trauma work conditions are in danger of experiencing psychological and personal disturbances that limits their ability to function professionally (Beck & Beck, 2011).

For this study, all the participants were licensed professional clinical counselors that attended accredited academic institutions and participated in a curriculum on mental health practices. In this study, the participants discussed learning the general principles of theory; however, in their program effective clinical skill sets in the diagnosis and treatment for youth with problem sexual behaviors were lacking. The literature supports that counselors working with youth with problem sexual behaviors who lack the appropriate level of education, expertise, and instruction are in danger of providing clinical services that do not produce positive outcome for the client (Stovering & Hart, 2013). Chassman, Kotter, and Madison (2010) found that issues exists in academic institutions such as academic or preservice counseling, and counselors that lack prerequisite skill sets in diagnosis and treatment of youth with problem sexual behaviors. Further, previous research has established that academic institutions and mental health programs should recognize the importance for new and counselors-in-training to have prerequisite skills that specifically target the needs and interventions for youth with problem sexual behaviors. As a result, counselors who lack the appropriate clinical skills and training are at risk for impairment because of their inability to understand the clinical services needed for this population (Chassman et al., 2010: Nelson et al., 2002).

The evidence in this study supported the literature that academic institutions lack in providing a curriculum that addresses youth with problem sexual behaviors (Chassman et al., 2010; Nelson et al., 2002; Stovering et al., 2013). Therefore, potential suggestions and solutions from the participants provided more understanding on the necessity for academic institutions to incorporate curriculum that specifically address theory and practice for youth with problem sexual behaviors. In the interview sessions, the participants were engaged and expressive talking about counselor impairment. The literature supports that counselors are incompetent at performing professional responsibilities or professional services as a result, of emotional or mental distress or physical difficulties. Additionally, counselors who are impaired become limited in providing professional services and quality care to their clients (ACA, 2014; Pack-Brown, Thomas & Seymour, 2008; Thompson, Amatea, & Thompson, 2014; Welfel, 2010)). Thompson, Amatea, and Thompson (2014) directed attention to professional impairment that relate to issues surrounding unethical behavior and immoral decisions. For this study, during the interview sessions the participants strongly advocated for incorporating self-care strategies as a means to prevent impairment. I found literature that supports counselors who develop a self-care plan and integrate, meeting frequently with a supervisor and staff with more expertise for advice, maintain boundaries with clients, and attend professional development trainings and workshops are effective to help reduce impairment and burnout (Carter & Barnett, 2014).

As the interviews were ending the final response from participants' raised concerns on the ethical issues encountered working with youth with problem sexual

behaviors. Their responses focused primarily on counselor incompetence, confidentiality with minors, and the affect or consequence it presents to their professional integrity. Through the literature, I found that ethical challenges exist during the counselors practice, and they must use caution to abide by ethical practices and standards to maintain their professional values and professional identity (ACA, 2014; Gottlieb, Handelman, & Knapp, 2008). Additionally, the literature supports counselors who work with minors face challenges with ethical dilemmas such as confidentiality, counselor competence, and reporting child abuse and child neglect (APA, 2010; AMHCA, 2010; CDC, 2012; Department of Health and Human Services, 2012; Lawerence & Kurpius, 2000). Counselors should use caution that ethical principles are practice to avoid repercussions and legal actions (Remely & Herlihy, 2010). The information provided in this study showed data that ethical issues continue to persist in counseling youth with problem sexual behaviors. The literature supports counselors should dismiss unethical behavior that interferes with competence in the profession, and the welfare of the client (ACA, 2014; APA, 2010; Remley & Herlihy, 2010). Furthermore, counselors should abide by the principles of professional ethics for making moral decisions, and ethical behavior (Welfel, 2010)), and ethical intelligence to empower their perception and personal responsibility (Pope & Vasquez, 2016). For this study, the information based on the participant’s responses was beneficial in providing a broader scope to understand the ethical issues counselors encounter when working with youth with problem sexual behaviors. To ensure that the interpretation did not exceed the data, findings, and scope of this study, transcendental phenomenology

allowed me as the researcher to interview, transcribe, analyze, and interpret the data based on the responses from the participants.

Limitations of the Study

The limitations specifically related to the results of this study are; (a) licensed professional clinical counselors (LPCCs), (b) 1-3 years of clinical counseling, (c) generalizability for the sample size were for one city in Ohio.

Recommendations

The results of this study revealed that although previous research on this subject is authentic, there continues to be a need for further research. There are several research studies conducted on mental health professional's experiences working with youth with problem sexual behaviors, however, not many on LPCCs and their professional competence and value is affected. Based on the evidence, recommendations for this study included, academic institutions to have a curriculum that specifically address youth with problem sexual behaviors, and mental health agencies that provide counseling services to youth with problem sexual behaviors incorporate additional professional development, workshops, and trainings to counselors.

Implications

This research study explored the lived experiences of counselors working with youth with problem sexual behaviors. The findings in this study, heighten awareness of the prerequisite skills necessary to effectively diagnose and treat youth with problem sexual behaviors, and protect counselors from impairment. The implications for positive social change provided an opportunity to increase understanding of counselor's

perceptions on the clinical skills most effective for quality client care and outcomes. The information obtained from the counselors in this study, can emend certification areas closely associated to the requirements and clinical skill sets for working with youth with problem sexual behaviors.

The important issues emerging from the findings for this study are that, (a) counselors lack prerequisite skills to be effective working with youth with problem sexual behaviors, and (b) counselors implement self-care strategies as a coping mechanism. Based on the findings of this study, academic institutions need to ensure adequate clinical skill sets for youth with problem sexual behaviors present more thoroughly to better prepare new and future counselors who choose to work with this population. The literature suggests that, early preparation and training could help counselors better prepare how to work with youth with problem sexual behaviors (Stovering & Hart, 2013). Additionally, the literature suggests that counselors who lack prerequisite classes and instruction are at risk for impairment in their professional performance (Ryan et al., 2010).

Another implication of these findings is that individual self-care strategies differ for each person. For example, one participant described, “having a strong faith and spending time in church and praying”, as the self-care approach they use when feeling frustrated and stressed. Another participant discussed, “physical exercise such as, bike riding, and walking,” as their self-care methods. Additionally, one participant mentioned, “getting away and taking a vacation”, are their self-care techniques. The literature supports that counselors’ recognizing one’s self-knowledge and care promotes

ethical behavior in providing fair and equal treatment to clients, and maintain professionalism (Welfel, 2010)). Additionally, literature supports that counselors who develop a self-care plan manage occupational stressors and maintain a level of professionalism to provide quality clinical services and lessen symptoms associated with impairment (Thompson et al., 2014). Therefore, counselors who have the appropriate prerequisite skills and training are capable of professional practice, which is demonstrated through increased job effectiveness, decreased or prevented impairment, potential job satisfaction, and longevity on the job.

Conclusion

Research studies showed that youth ages 12–17 are responsible for 16–19% of all sexual crimes committed in the United States every year (Efta-Breitbach & Freeman, 2013; Finkelhor, 2012; Seto & Lalimiere, 2010). LPCCs working with youth with problem sexual behaviors need to have specific clinical skills and training to be effective in providing the appropriate diagnosis and treatment for this population. Ryan, Lane, and Leversee, (2010) contended that counselors' who lack specific clinical skills working with youth with problem sexual behaviors are in danger of impairment in their professional performance because of unpreparedness to understand and target their needs. This study endeavored to understand the lived experiences of counselors working with youth with problem sexual behaviors and illuminate counselors' perceptions of prerequisite skills necessary to work with this population and decrease the risk for impairment.

The findings from this study showed that counselors encountered challenges working with youth with problem sexual behaviors that affected their emotional, mental, and occupation status. Linnerooth et al., (2011) found that counselors who are highly exposed to trauma work conditions, situations, and events are impaired professionally. Other findings from this investigation revealed that counselors were unprepared academically to work with youth with problem sexual behaviors and wanted more of practical training along with learning theory. In conclusion, counselors need to incorporate professional development, training, and self-care strategies for effective diagnosis and treatment to work with youth with problem sexual behaviors. Additionally, counselors-in-training need to have specific clinical skills to work with this population as a measure to reduce and prevent impairment.

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Appendix A: Interview Questions

- Tell me about yourself (where did you grow up, family, educational background)
- How long have you worked in the mental health profession?
- How long have you been in your current position? What are your responsibilities?
- What led you to the decision to become a counselor and work with youth with problem sexual behaviors?
- What is a typical day like for you?
- What positive and negative experiences of being a counselor have you had?
- Does working with youth with problem sexual behaviors have an impact on you? If so, what impact?
- How do you cope or deal with the challenges that come with being a counselor working with youth with problem sexual behaviors? How do you stay motivated?
- What else would you like to share with me about your experiences with youth with problem sexual behaviors?
- Do you feel you are prepared to work with this population? If not what do you feel is needed to be prepared?