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Original Article

Counseling Ethics: The Case of Sexuality Information

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Abstract

Objective: The study aimed to identify Colombian adults' positions in cases in which a counsellor can and should not do so in a situation where parents who are uncomfortable with all issues related to sexuality ask their daughter's school counsellor to help answer her questions about these topics.

Materials and methods: A convenience sample of 180 adults, including 19 school counsellors, was presented with a set of 24 vignettes created by orthogonally crossing three factors: (a) the context of the request (e.g., parents ask the educator to limit sexual information to purely biological aspects), (b) whether the adolescent requests additional information, and (c) the type of information provided by the educator (e.g., comprehensive information, including abortion).

Results: A cluster analysis of participants' appropriateness judgments regarding counsellor's behavior revealed four qualitatively different positions: *Depends on adolescent's request* (5%), *Completeness of information* (26%), *Biological information is insufficient* (31%), and *at educator's discretion* (16%). In addition, 18% (most religious) expressed no discernible position.

Conclusion: The majority of participants (57%) thus expressed the view that the most appropriate behavior on the part of the counselor was to provide the most comprehensive information possible, and certainly not to focus solely on the biological aspects of sex education during counseling. This view was largely independent of contextual elements such as the limits to communication set by the parents or even the limits to communication set by the adolescent.

Keywords: Counseling; Ethics; Sexuality Information; Colombia

Introduction

Suppose that parents who are uncomfortable with all matters related to sexuality ask their 14-year-old daughter's school counsellor to help answer her questions about these issues. Suppose that the same parents insist that the counsellor should limit themselves to the biological aspects of sexuality. What would be the most appropriate behavior for this professional? Should the counsellor comply with the

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parents' wishes and restrict themselves from informing young adolescents about the biological aspects of human reproduction? If the adolescent asks additional questions, can the counsellor go so far as to discuss the emotional aspects of sex? If the adolescent does not have any questions but seems mature, can the counsellor, on her own initiative, address aspects of sexually transmitted infection prevention and contraception? If the adolescent initiates the process on her own, behind the backs of parents who are reluctant to communicate on the subject, should the counsellor discuss all these topics with her? This study aimed to identify the positions of Colombian adults towards school counsellors, particularly regarding what they believe a counsellor can or cannot do in situations related to the sexuality of adolescents in their schools. Parents who felt uncomfortable with sexuality-related topics sought assistance from their school counsellor to address their questions in these areas.

Although the school counsellor has, in theory, been well trained to respond to this type of request, she or he may be torn between multiple tendencies. On the one hand, the counsellor has been taught during her or his time at university, and it is well known, as an experienced professional, that comprehensive sexuality education is the best way to reduce the risk of adolescents engaging in hazardous relationships prematurely (1). Therefore, the counsellor would be inclined to respond positively to any request from the adolescent and even go beyond that if she or he perceived shyness in the adolescent. On the other hand, the counsellor has his/her own legitimate views on the appropriateness of sexuality information, which may lead to a lack of conviction when responding to this type of request. For example, as a parent, the counsellor may feel that sexuality is a hot-button issue and that the family setting is the only morally appropriate place to deal with these issues (2). In addition, as an employee of the school, the counsellor may feel that going beyond what the parents have deemed appropriate may expose her or him to retaliation from the principal if the parents complain. As a citizen, the counsellor may consider that she or he owes loyalty to his political party of reference, which, for example, has always favored abstinence-based sex education programs in schools (3). As a believer, the counsellor may consider that only the deity has the right to intervene in such matters. Of course, a professional is obliged to perform her duty, regardless of her beliefs, but a balance must be struck when acting.

Educational counsellors in Colombia, from various fields such as Psychopedagogy, Psychology, Education, Pedagogy, Sociology, and other social and human sciences, play a crucial role in the holistic development of children and young people in the school environment, ensuring their fundamental rights. Although not all are experts in human sexuality, they are expected to provide comprehensive support to students. The Colombian Ministry of Education has assigned these professionals the responsibility to address, advice, and monitor groups as well as individual and institutional processes that promote well-being within educational communities. However, the broad functions assigned by the ministry encompass a variety of phenomena, ranging from preventing psychoactive substance use and reducing suicide risk to participating in parent programs. The educational reality in Colombia poses ethical challenges for counsellors: on the one hand, they lack solid training to address sexuality-related issues based on evidence; on the other hand, they must adhere to the rules of each educational institution, some of which may be very traditional or have a religious focus, as in other countries like Philippines when sexual education is almost a taboo (4). Additionally, they must comply with Colombian laws and regulations on education and adapt coherently to the diverse cultural realities of the country (5).

This is intertwined with the difficulties that the different interventions of sexual and reproductive health education programs have presented in evaluating and systematizing the effectiveness of the interventions. Following Evans et al. (6), with the intention of enhancing sexual health interventions and recognizing cultural variables of Latino adolescents as well as their beliefs and practices, it is important to examine the effectiveness of the interventions and programs carried out. According to a meta-analysis study conducted, interventions focused on Latino adolescents and/or their parents in schools and community settings have focused on increasing abstinence and/or promoting safe sex behaviors and knowledge, but have not resulted in reductions in adolescent pregnancy rates. However, it is important to note the lack of focus on school actual work of school counsellors in sexuality education. Often, sexual and reproductive health programs lack adequate integration with pedagogical guidelines for school counsellors, limiting their effectiveness.

Based on the demands and realities of counselors in schools, Anami et al. (7) proposed peer counseling as an effective alternative to address sexual education in adolescents, given the gap between them and school counselors. Training students to be peer counselors encourages openness in discussions of sexuality and allows them to educate their peers effectively. Online training is presented as a practical and economical solution, easing the burden on counseling professionals. It is crucial that counseling experts prepare students for this role, anticipating that, in the future, this training will be coordinated by professional counselors for comprehensive support in adolescent development.

According to the experience of training counselors, expressed by the study by Savitri et al. (8), the fundamental thing is that counselors have spaces for understanding the development of adolescent sexuality, particularly due to the changes and challenges that are currently being experienced, in order to be able to outline new ways to design, develop and evaluate the work of counseling itself. This will allow the training processes in healthy sexuality to be enhanced.

People's Perceptions on Sex Education in Schools

Sexual education for young people is closely linked to culture. Sexual education can be more or less open depending on the values of society. Currently, it seems that there are no parents or caregivers who do not consider sexual education during childhood and adolescence, as it can help prevent infections or lead to a healthy sexual life. However, the content of sexual education changes with the level of cultural openness of cultures (9). Similarly, it has been observed that there are no correlations between the sociocultural level of young people and their level of sexual knowledge (10). Apparently, even though young people may have low or moderate knowledge about sexuality, their attitudes towards sexual education are quite favorable (11). It seems that parents, schools, and in general, members of society lack clarity on what should or should not be taught to young people (12). In some cases, the issue with sexual education is not only that parents or caregivers are unwilling to talk to their children, or that the children do not want to listen. As observed, common adults - even if they are willing to discuss sex - do not have sufficient knowledge to comprehensively educate their children. Thus, their primary knowledge often comes from Internet searches (13).

In Western countries in the United States of America, most people tend to endorse the introduction of sex education into the classroom curriculum. Adolescence is a time when young people undergo both physiological and behavioral transformations as an opportune time to build intellectual and emotional grounding before entering adulthood (14). However, unwanted pregnancies, sexual abuse, and sexually related infections have been reported in most of these states. Thus, it appears that the objectives of sex education have not been fully realized everywhere, although the incidence rate of these occurrences varies widely from country to country (1).

In Latin American countries, in contrast, sex education does not appear to have been fully agreed upon by civil society or bodies such as the Catholic Church (15-17). Jerves et al. (18) reported that Ecuadorian parents tend to express restricted views on sex education based on traditional religious values that present sex as a morally reprehensible and physically dangerous activity. Sevilla et al. (19) reported that Colombian parents tend to limit themselves to providing young people with information on the initiation of sexual relations and the material precautions to be taken, rather than on the affective and relational settings in which these relations should take place.

Pineda et al. (20) showed that (a) 36% of their sample of adults living in Bogotá thought that parents should provide comprehensive information and go so far as to recommend rather than discourage premarital sexual experience; (b) 6% thought it was never appropriate to talk about sexual topics in the family; (c) 4% preferred to delegate this responsibility to the school nurse; (d) 11% thought that parents should limit themselves to providing information about the biology of sexuality; and (e) 28% thought that parents should indeed provide comprehensive information but with a recommendation of abstinence. These positions did not vary significantly according to the sex and age of the adolescents.

Accordingly, Calgarotto (21) carried out a historical review of the literature on sexual education in Brazil, denoting the tendency to provide information on the biological parameters of sexuality. From there, he considers it vital that training commitments be generated from scientific bases, overcoming historical notions with tendencies towards cultural notions that make the transformation of training commitments difficult. With this, the counselor/teacher cannot focus on purely biological

aspects, but invites sexuality to be understood in comprehensive training that also enriches the mental health of students.

The Present Study

This study was conducted as an extension of the study by Pineda Marin et al. (20). Its objective was to map the positions of Colombian adults regarding the behavior that a school counsellor should or should not adopt when it is up to her or him, due to the parents' request or due to the request of an adolescent girl, to provide information of a sexual nature during a consultation or series of consultations. In Colombia, families reflect a wide demographic diversity and entrenched cultural beliefs, with a predominantly nuclear structure representing 56.7% of households and households without elderly adults being the most common, constituting 39.5%. This family diversity intertwines with the incidence of poverty, where a greater impact is noted in households headed by females than in those headed by males, especially in nuclear and extensive family composition households, where the difference reaches up to 4 and 3 percentage points, respectively. Furthermore, income distribution reveals economic disparity, with over half of households situated in the first and third income quintiles, notably households without elderly adults in the first quintile, and intermediate-generation generational households in the fifth quintile. It is also observed that income inequalities are more pronounced in generational households solely with elderly adults, while multigenerational households show the least disparity between income quintiles. These data underscore the complexity of family and economic dynamics in Colombia, where family structure and income distribution play a crucial role in the quality of life and well-being of its inhabitants, in a context where differences in child-rearing persist, although a shift towards more egalitarian child-rearing is increasingly evident, promoting values of equity and empowerment for both genders (22).

In Colombia, sex education is, in theory, present in all schools (23). It is generally limited to the biological aspects of sexuality. Its general philosophy is that of the abstinence-based programs that used to exist in the United States (24). This is considered one of the reasons why the adolescent pregnancy rate (ages 15-19) is still very high in this country (about 9%) compared to countries where comprehensive sex education became the norm a decade ago (about 3% in the United States) or has been the norm for a long time, such as in the Netherlands (25). This rate is close to that observed in neighboring countries, where similar programs are implemented in schools (about 9% in Panama and about 7% in Peru). It has been projected that, given the provisions made at the ministerial level regarding sexual education, Colombia will make significantly less progress than its neighbors in reducing adolescent pregnancies. By 2030, Colombia will be the country with the highest rate of adolescent pregnancy in Latin America (26).

Based on previous findings, four qualitatively different positions regarding the behavior that a school counsellor should adopt when it is up to her or him to provide information of a sexual nature during a consultation were expected. (a) First was the position according to which the counsellor must not go beyond what the official sex education program provides. In all cases, participants thought that the counsellor should adhere to the biological aspects of sex education. (b) The second position was that the counsellor must adapt her or his behavior to the adolescent's wishes. If an adolescent has specific requests, the counsellor should try to accommodate them as best as possible (e.g., by providing information about contraception and abortion). (c) The third position was that the counsellor should adapt their behavior to the parents' wishes. If the parents want only the biological aspects to be discussed, then there is no choice not to go beyond that. (d) Finally, it was expected that a certain percentage of participants would, owing to the controversial nature of the subject, decline to express a personal position or agree with any decision taken by the counsellor (20).

Materials and methods

Participants: The participants were a convenience sample of 180 adults (42% men) aged 18–84 years (M = 34.37, SD = 14.28) residing in Bogotá, Colombia. The demographic characteristics are presented in Table 1. Nineteen were school counselors from educational institutions in Bogotá. They were contacted via snowball sampling.

Some participants (N = 93) were approached from different districts of the city. They were requested to participate in the survey while walking on the main pedestrian sidewalks in their barrio, usually in nearby areas of public facilities, commercial centers, and churches. The participation rate was 59% for the virtual participants and 80% for the face-to-face respondents.

Table 1: Demographic Characteristics of the Sample. Composition of the Clusters

	Clusters					Total
	DAR	COI	BII	AED	UND	
Age						
18-23 years	4(7)	24(40)[ab]	12(20)[a]	8(13)	12(20)	60
24-39 years	2(3)	12(21)[a]	14(25)[b]	15(26)[a]	14(25)	57
40+	3(5)	11(17)[b]	30(48)[ab]	6(9)[a]	13(21)	63
Gender						
Male	5(6)	26(35)[a]	16(21)[a]	11(15)	17(23)	75
Female	4(4)	21(20)[a]	40(38)[a]	18(17)	22(21)	105
Parenting						
No	6(5)	37(29)	34(27)	23(18)	27(21)	127
Yes	3(6)	10(19)	22(41)	6(11)	12(23)	53
Socio-Economic Status						
Low	1(4)	6(25)	6(25)	2(8)	9(38)	24
Average	1(1)[ab]	34(36)[a]	25(27)[a]	14(15)	20(21)	94
High	5(10)[a]	5(10)[a]	22(45)[a]	8(16)	9(19)	49
Very High	2(15)[b]	2(16)	3(23)	5(38)	1(8)	13
Religious Involvement						
Very Low	1(2)	19(45)[abc]	8(19)[a]	9(22)	5(12)	42
Low	5(7)	18(25)[a]	23(32)	11(16)	14(20)	71
Average	3(10)	5(17)[b]	10(33)	4(13)	8(27)	30
High	0(0)	5(14)[c]	15(41)[a]	5(13)	12(32)	37
Sex Education						
No	2(2)[a]	27(23)	47(39)[a]	21(18)	22(18)	119
Yes	7(11)[a]	20(33)	9(15)[a]	8(13)	17(28)	61
Condition						
Virtual	2(2)	26(30)	26(30)	15(17)	18(21)	87
Face to Face	7(7)	21(23)	30(32)	14(15)	21(23)	93
Professional						
No	9(5)	43(27)	51(32)	23(14)[a]	35(22)	161
Yes	0(0)	4(21)	5(26)	6(32)[a]	4(21)	19
Total	9(5)	47(26)	56(31)	29(16)	39	180

Values in parentheses are the percentages calculated for each row. DAR = Depends on Adolescent's Request, COI: Completeness of Information, BII: Biological Information Insufficient, AED: At Educator's Discretion, UND: Undetermined. Values with the same superscript are significantly different ($p < 0.05$. Parenting =if the participant was or was not a parent. Sex education = refers to having any sexual education in their school.

The main explanation for not participating in the study was the time constraints. The remaining participants (N = 87) were surveyed online due to mobility restrictions during time of pandemics (COVID-19).

Material

The survey material consisted of 24 cards describing situations in which a school counsellor was asked to provide sexual information to a 14-year old female adolescent who approached them spontaneously or was sent by their parents. Each scenario contained three pieces of information: (a) the context of the request (the adolescent approaches the educator because they do not receive any information from their parents, or the parents ask the educator to provide sexual information but limit it to purely biological aspects, or the parents give the educator a free hand), (b) whether or not the adolescents asked for additional information beyond the mere biological aspects, and (c) the kind of information provided by the educator (biological information only, additional information on the emotional aspects of sexuality, additional information on pregnancy and infection prevention, or comprehensive information including abortion).

The scenarios were obtained by orthogonally crossing these three factors. The design was Context x Request x Information, 3 x 2 x 4. An example

scenario (translated from Spanish) is as follows: "Mrs. López is the psychologist and guidance counsellor at the Francisco de Paula secondary school of Barranquilla. Alejandra is an adolescent who studies at that school and is 14 years old. Alejandra has gone to see Mrs. López on their own initiative. The adolescent wants to have information about sexuality and sexual relations. They say that, at home, their parents refuse to answer their questions. Mrs. López explained to Alejandra the biological aspects of sexuality, specifically human reproduction, using books and images appropriate to their level of understanding. Alejandra listens actively and says they have questions. For example, they want to know some things related to the emotional aspects of sexuality; they want to know more about sexually transmitted infections, contraceptive methods, and what they should do in case of an unwanted pregnancy or infection. Mrs. López, therefore, decides to explain to Alejandra some things about the emotional aspects of sexuality (e.g., recognizing their feelings, the enjoyment of sexuality, the ability to assert their decisions). Additionally, Mrs. López believes that she should also explain to Alejandra aspects related to the prevention of sexually transmitted infections (their causes and consequences) and how to use methods that also serve to avoid unwanted pregnancy (how to use male and female condoms and contraceptive pills). To what extent do you think Mrs. Lopez's behavior was appropriate"? Responses were provided on an 11-point scale, with values ranging from Not at all appropriate (0) to completely appropriate (10).

Procedure

Data collection was conducted in 2020 and 2021. This procedure followed Anderson's (27) guidelines for this type of study. For participants who were surveyed face-to-face, the data were collected in a quiet room. After an initial encounter on the street, they agreed to meet at home later with the participant. A virtual call was made to the participants to collect virtual data. In this call, the participants enabled the researchers to contact and explain the informed consent procedure as well as conduct the familiarization phase. This phase was done in a remote synchronous manner to ensure that the participant understood how to answer and was able to answer any questions, if they considered it pertinent. After the familiarization exercise, participants answered the entire instrument through the platform's link.

In both conditions, participants required between 35 and 40 minutes to provide answers. None of the participants commented on the number of statements or expressed doubts about the plausibility of the situations presented.

A demographic questionnaire was administered at the end of each session. Some respondents spontaneously voiced their views on the topic and these views were registered. This study conformed to the ethical recommendations of the Colombian Society of Psychology. Total anonymity was preserved, and informed consent was obtained from all participants. The study was approved by the Bioethics Committee of Konrad Lorenz University.

Results

The means and standard deviations for each of the 24 scenarios are presented in Table 2. As widely varying positions were expected, a cluster analysis, using the K-means procedure (28), was performed to qualitatively detect different judgment patterns. As four positions were expected, a four-cluster solution was first applied. Subsequently, two-, three-, five-, six-, seven-, and eight-cluster solutions are examined. Figure 1 shows the decrease in the average distance to the centroid as a function of the number of clusters selected. The five-cluster solution seemed to be the most appropriate solution, as it provided the most intelligible patterns (28).

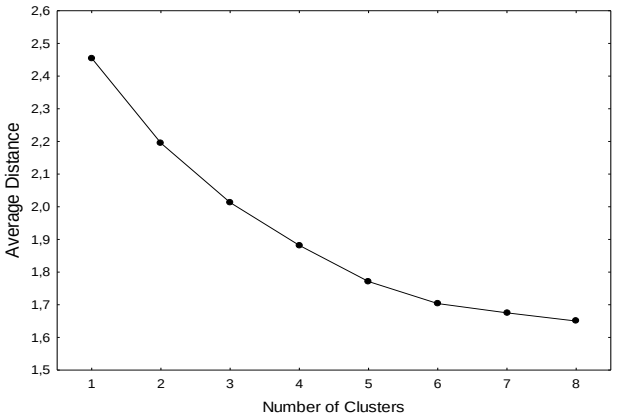

Figure 1: Decrease in the average distance to the centroid as a function of the number of clusters

An overall ANOVA was performed on the observed ratings for each profile with a Cluster x Context x Request x Information, 5 x 3 x 2 x 4 design. Because of the large number of comparisons, the significance threshold was set at .001. Table 3 presents the main results.

Table 2: Means and Standard Deviations Observed for Each Scenario

Additional Information	Context of the Demand	Information Provided	M	SD
Do not Request	Adolescent's Initiative	Biological	4.94	3.16
Do not Request	Adolescent's Initiative	Emotional	7.80	2.16
Do not Request	Adolescent's Initiative	Prevention	8.31	2.35
Do not Request	Adolescent's Initiative	All Aspects	8.24	2.69
Do not Request	Biological Information	Biological	4.96	3.14
Do not Request	Biological Information	Emotional	7.28	2.39
Do not Request	Biological Information	Prevention	7.84	2.51
Do not Request	Biological Information	All Aspects	7.81	2.76
Do not Request	Carte Blanche	Biological	4.14	3.10
Do not Request	Carte Blanche	Emotional	6.93	2.52
Do not Request	Carte Blanche	Prevention	8.18	2.34
Do not Request	Carte Blanche	All Aspects	8.36	2.27
Request	Adolescent's Initiative	Biological	3.12	3.15
Request	Adolescent's Initiative	Emotional	6.46	2.88
Request	Adolescent's Initiative	Prevention	8.34	1.85
Request	Adolescent's Initiative	All Aspects	8.64	1.95
Request	Biological Information	Biological	3.57	3.16
Request	Biological Information	Emotional	6.38	2.77
Request	Biological Information	Prevention	8.12	1.95
Request	Biological Information	All Aspects	8.53	2.09
Request	Carte Blanche	Biological	3.21	3.20
Request	Carte Blanche	Emotional	5.86	2.97
Request	Carte Blanche	Prevention	8.05	2.06
Request	Carte Blanche	All Aspects	8.70	1.95

Biological Information: The parents ask the educator to provide sexual information, but limit it to purely biological aspects. Biological = Biological information only is provided. Emotional = Additional information on the emotional aspects of sexuality is provided. Prevention = Additional information on the emotional aspects of sexuality and on pregnancy and infection prevention is provided. All Aspects = Comprehensive information including abortion is provided.

Figure 2 shows the mean appropriateness scores for the five clusters. The first cluster (N = 9, 5% of the sample) was labelled *Depends on the adolescent's request.*

Table 3: Main Results of the ANOVA

Factor	df	MS	F	p	η^2p
Cluster	4	1400.54	90.61	0.001	0.67
Request	1	117.93	19.26	0.001	0.10
Cluster x Request	4	50.61	8.26	0.001	0.16
Context	2	13.02	5.19	0.01	0.03
Cluster x Context	8	7.34	2.93	0.001	0.06
Information	3	1 805.78	316.24	0.001	0.64
Cluster x Information	12	475.84	83.33	0.001	0.66
Request x Context	2	3.62	1.55	0.21	0.01
Cluster x Request x Context	8	5.04	2.16	0.03	0.05
Request x Information	3	589.69	129.31	0.001	0.42
Cluster x Request x Information	12	153.20	33.59	0.001	0.43
Context x Information	6	19.44	8.27	0.001	0.05
Cluster x Context x Information	24	4.99	2.12	0.001	0.05
Request x Context x Information	6	6.13	3.20	0.001	0.02
Cluster x Request x Context x Information	24	2.82	1.47	0.07	0.03

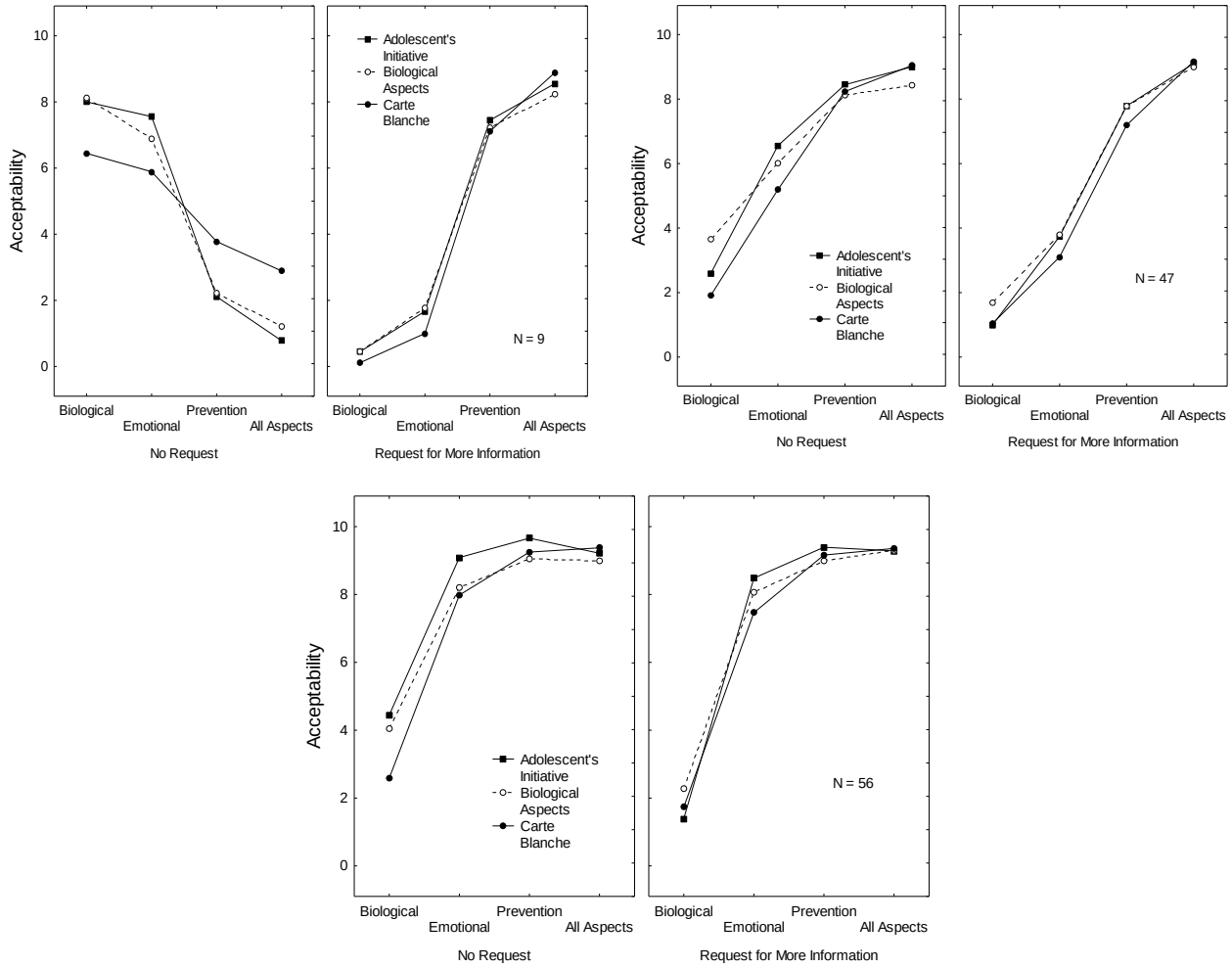

Figure 2: Mean rating observed for three of the five cluster: Depends on the adolescent request (top row), Completeness of information (middle row), and Biological information is insufficient (bottom row). Mean ratings are on the vertical axis. The educator's behaviors are on the horizontal axis. Each curve corresponds to a context. Each panel correspond to one level of the adolescent's request.

This designation was given because, as can be seen in Figure 2 (top panels), when the adolescent has not formulated specific questions (left-hand panel), the most appropriate behavior is for the educator to stick to the biological aspects, whereas when the adolescent formulates additional questions (right-hand panel), the most appropriate behavior is to answer all of these questions. In the first case, the mean ratings were higher when the educator limited themselves to informing about biological aspects (M = 7.52, SE = 1.90) than when the educator went so far as to provide complete information (M = 1.63, SE = 1.14). In the second case, the mean ratings were lower when the educator was informed about biological aspects only (M = 0.33, SE = 0.25) than when the educator provided complete information in response to the request (M = 8.56, SE = 1.94), η^2_p = .83. The Context factor has just, in the first case, a moderating effect; when the parents have given the educator carte blanche, the latter's behavior is less of a determinant of appropriateness (6.44 – 2.89 = 3.55) than when the parents have demanded that the educator limit herself to the biological aspects (8.06 – 1.00 = 7.06), η^2_p = .26. As can be seen in Table 1, participants of a very high socioeconomic level and those who benefited from sex education when they were young expressed this position more frequently than participants of lower levels or those who did not benefit from sex education.

The second cluster (N = 47, 26%) was called *Completeness of information*. It was given this designation because, as can be seen in Figure 2

(middle panels), the most appropriate behavior for the educator is to inform the adolescent as completely as possible, regardless of the level of her request. The adolescent's request factor had only a moderating effect; when the adolescent did not express additional requests, limiting oneself to biological or biological-emotional aspects was, for the educator, considered slightly less inappropriate than when the adolescent had questions. That is, in the case of not requesting anything, the educator's behavior was less of a determinant of appropriateness (8.82 - 2.72 = 6.10) than in the case of requesting something additional (9.10 - 1.25 = 7.85), $\eta^2_p = .39$. As can be seen in

Table 1, younger participants, males, participants of lower socioeconomic status, and participants who were not very religious expressed this position more frequently than other participants.

The third cluster ($N = 56$, 31%) was a variant of the preceding cluster. labeled *Biological information is insufficient*. This is because, as shown in Figure 2 (lower panels), all educator behaviors were considered adequate ($M = 8.91$, $SE = 0.34$), except for limiting oneself to biological information ($M = 2.75$, $SE = 0.48$), $\eta^2_p = .89$. As shown in Table 1, older participants, females, participants with high status, and participants who never benefited from sex education expressed this position more frequently than younger participants, males, participants with low status, or participants who benefited from education. 48% of people over 40 years of age were located in this cluster, and more women than men were grouped together (38% of the total sample).

The fourth cluster ($N = 29$, 16%, not shown) was labeled *at educator's discretion*. This designation was given because all educator behaviors were considered appropriate ($M = 8.81$, $SE = 0.47$), regardless of other circumstances. As can be seen in Table 1, middle-aged participants, participants with a very high socioeconomic status, and school counsellors expressed this position more frequently than other participants.

The fifth cluster ($N = 39$, 18%, not shown) was labeled *Undetermined.* This was because all ratings were close to the middle of the response scale ($M = 6.20$, $SE = 0.45$), and the factors had no discernible effects. Participants with a high level of religious involvement ($N = 67$) expressed this position more frequently than participants with low levels ($N = 113$, $p < .05$). 23% of the men were located in this cluster, 21% of the women in the total sample, and 38% of the people with a low socioeconomic status were also located in this cluster.

Discussion

A majority of participants (57%) expressed the view that the most appropriate behavior on the part of the counsellor was to provide the most comprehensive information possible and certainly not to focus on the biological aspects of sex education alone during counseling. This view is largely independent of contextual elements, such as the limits to communication set by parents or even the limits to communication set by adolescents. This finding is consistent with results reported by Pineda et al. (20), who showed that a large majority of their sample of Colombian adults favor sex education based on comprehensive information about it, even if abstinence before marriage is preferable for a minority of them. Likewise, it aligns with the results of the review carried out by Calgarotto (21) on the training frameworks in Brazil on sexuality. This reinforces the idea of commitments and policies aimed at comprehensive education processes in accordance with the frameworks of transformation of society, the needs of adolescents, and the means of access, focusing on providing information on the biological aspects of sexuality.

Therefore, if a counselor goes beyond what the family expects of him or her or even beyond what is asked of him or her by the interested party, such behavior is not considered problematic for the majority of the participants. This view is probably driven by the belief that an adolescent girl cannot reasonably embark on life and thus initiate sexual relationships without knowing the full range of aspects that characterize such relationships. This view is in any case the one adopted by official international bodies such as the United Nations Population Fund (29).

A minority of participants (16%, mostly elite) did not dispute the idea that providing comprehensive information about sexuality is appropriate, but they did consider that the counselor may have his or her own beliefs about the subject (e.g., religious beliefs) and therefore may not feel comfortable with the request. In this case, if the counselor strictly adheres to biological aspects, his or her behavior is still considered appropriate. This position is understandably the most common (32%) among counselors. Another minority of participants (5%, mostly of high socioeconomic status) also did not dispute the fact that the information given by the counsellor could be complete, but took into account

the attitude of the adolescent making the request. Going beyond the request of the concerned person is not considered appropriate.

Thus, the way in which spaces of trust, relational dynamics, and group management, among others, can be generated between adolescents and the counselor is vital. Thus, it is necessary to weigh the alternatives in the training processes of both the counselors and students. This implies knowing the latent situations in the school regarding sexuality; the needs according to the ages of the students; and the physical, operational, methodological, and pedagogical resources available. Likewise, following Savitri et al. (8), the way in which adolescent sexuality is being understood and the approach that counseling has to it are aspects that will allow the promotion of healthy sexuality.

A possible bet is that expressed by Anami et al. (7), in which adolescents can be trained to be a reference of information for other students and advise them on different topics of sexuality. An aspect that also brings with it challenges for education itself, especially to demonstrate not only the satisfaction of these intervention programs in schools but also the impact on the systematization and monitoring frameworks.

Finally, a substantial minority of participants (18%, the most religious) did not express positions that could be characterized. Among these, it appears very likely that it is difficult to express a position on a subject considered taboo within certain segments of society or the community to which it belongs. This result is consistent with the results of Calgarotto (21), in which traditional and biological notions of sexuality are maintained in some sectors of society as sufficient elements for the training process. The findings reported by Pineda et al. (20) show that a minority of their sample of Colombian adults express discomfort with sex education either because it is considered inappropriate or because the information should, in their view, be delegated to health personnel.

Limitations and Future Studies: This study had some limitations. First, since a small convenience sample of adults living in one area of Colombia (the capital district) was studied, the present findings must, therefore, be generalized with care. Second, the participants were presented with vignettes that depicted realistic situations; they were not facing real situations. Third, the characters depicted in the story were always young adolescent female. Future studies should examine whether a gender effects can be detected. Fourth, participants were not asked any questions to help them understand the reasons behind the appropriateness judgments. Future studies should try to relate participants' positions and reasoning. Fifth, the participants' psychological characteristics were not assessed. Future studies should relate participants' positions to their core values, personality disposition, and political orientation.

Conclusion

The implications of this study suggest considerations in the political, sociocultural, and educational realms. These findings emphasize the importance of having evidence-based data reflecting the judgments of the general population on sexual education, a historically taboo topic. The majority of participants advocated for comprehensive sexual education that goes beyond biological aspects, highlighting the need for educational programs addressing the physiological, emotional, social, and ethical dimensions of sexuality. Additionally, the importance of considering counselors' personal beliefs and values in the educational process is underscored, emphasizing the need for training in cultural competencies and promotion of an inclusive and respectful environment for the exchange of diverse perspectives.

This study also highlights the importance of fostering trust and positive dynamics between adolescents and counselors, necessitating the development of strategies to strengthen these relationships and address the specific needs of adolescents regarding sexual education. Furthermore, the need to address cultural and religious barriers hindering sexual education is evident, including the necessity of adopting culturally sensitive and respectful approaches in sexual education programs to meet the needs of all groups within the school community.

Conflict of Interests

Authors declare no conflict of interests.

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