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Research, Practice, and Education

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# The Sexual Values and Behaviors Discrepancy Model

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Founded in theory and empirical research, we developed the Sexual Values and Behaviors Discrepancy Model (SVBDM) as reflective model for counselors to follow in order to assist their clients in safely reducing discrepancies between their ideal and practiced sexual beliefs, values, and behaviors. The SVBDM is a wellness-informed and sex-positive approach to working with clients and is comprised of three steps: Identification and Operationalization of Potential Sexual Issues, Counselor's Self-Assessment, and Reducing Discrepancies and Maintaining Safety. We note practical implications and potential limitations of this model as well as recommendations for future research.

*Keywords:* sexuality, wellness, theory, supervision, relationships

## Introduction

Sexuality is an integrated component of healthy development across the lifespan (Mosher, 2017; Wong, 2015). As such, counselors are charged with promoting healthy development and holistic wellness in their work with clients, including the domain of sexuality (Council for Accreditation of Counseling and Related Educational Programs [CACREP], Standard 5.F.2.e, Council for Accreditation of Counseling and Related Educational Programs, 2016). Indeed, the counseling profession calls for the promotion of sex positivity (Burnes, Singh, & Witherspoon, 2017) and sexual wellness (Iantaffi, 2016) to meet the needs of clients who are presenting to counseling for issues related to their sexuality (Ayles & Haddock, 2009; Reissing & Giulio, 2010; Sanabria & Murray, 2018). Yet, some counselors report feeling undertrained and/or uncomfortable working with clients with sexual concerns (Harris & Hays, 2008; Bloom, Gutierrez, Lambie, & Ali, 2016).

Scholars noted the evolution of clients' counseling needs as society moves further from the early and mid 20th century when the majority of traditional counseling models originated (e.g., Bloom & Taylor, 2015). A primary concern is that clients are presenting to counseling with contemporary issues related to intimacy and sexuality (Hertlein & Stevenson, 2010) that are made more prevalent by the accessibility, affordability, and availability of the Internet (Cooper, 1998). Within the last decade, researchers have identified clinical issues related to adverse experiences with online dating (Ali & Bloom, 2018), online sexual solicitation (Rice et al., 2014), addiction to cybersex (Goldberg, Peterson, Rosen, & Sara, 2008), complications associated with client pornography use (Ayles & Haddock, 2009; Bloom & Hagedorn, 2014), and an

array of other clinical issues (Reissing & Giulio, 2010). Consequently, there is a call for counselors to address their personal and professional limitations when working with clients regarding sexual issues and for counselor education programs to "increase opportunities for counselors-in-training to receive formal sex education" (Bloom et al., 2016, p. 340).

When working with clients with issues related to their sexuality, it is important for counselors to remember to work within their boundaries of competence (American Counseling Association [ACA], 2014), as sexual issues can contain nuances that require additional training or referral to counselors who specialize in working with clients with sexual concerns (Yarber, 2013). Regardless of the specific clinical issue, theory remains an essential component (Corey, 2016) of ethical practice (ACA, 2014). However, in light of the gradations of more contemporary sexual issues and the continued evolution of society, a critical review of the literature failed to find a succinct, user-friendly model that is both grounded in theory and best practices. Therefore, founded on the effectiveness of the therapeutic relationship in creating positive client outcomes (Norcross & Lambert,

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2011), the strengths-based approach of wellness-informed counseling (Myers & Sweeny, 2005), and the essential role of differentiation in working with clients with issues related to sexuality (Heiden-Rootes, Brimhall, Jankowski, & Reddick, 2017; Schnarch, 1991), we propose the Sexual Values and Behaviors Discrepancy Model (SVBDM) to guide counselors in their work with clients who present with sexual issues that is founded in theory and best practices.

### Sexuality and the Counseling Field

Whereas today's counselors work from a strengths-based stance with clients (Burnes et al., 2017), psychiatrists in the United States in the 1930s viewed sexual issues (i.e., values and practices) from a lens of pathology (Chiang, 2010). As such, individuals performing less mainstream sexual practices were commonly pathologized. For example, homosexuality was once considered to be a result of childhood trauma that could be cured with treatment (Chiang, 2010; Drescher, 2008) and was only removed from the Diagnostic and Statistical Manual of Mental Disorders ([DSM]; American Psychiatric Association [APA]) in its sixth printing of its second edition in 1973 (Drescher, 2015). Even more recently, conversion therapy – the harmful application of counseling practice to change an individual's sexual orientation – has been universally condemned and considered unethical by the counseling profession (e.g., Human Rights Campaign, n.d.). The counseling profession's evolved stance regarding the practice of conversion therapy reflects the profession's greater understanding of the fluidity and variability of sexuality (Fairington, 2008), as well as the importance of minimizing harm, stigma, and the expression of microaggressions when working with clients pertaining to issues of sexuality (Drescher, 2015; Hermann & Herlihy, 2006; Hozid, 2013; Moleiro & Pinto, 2015).

Sexual practices and beliefs about sexuality are dynamic in nature (Yarber, 2013), and a variety of counseling issues (e.g., shame, emotional suppression, reduced sexual desire) might be related to individuals' adherence to strict gender roles and/or conservative beliefs about sex and sexual practices (Petersen & Hyde, 2011). Further, it is necessary to note that labels of mental illness (i.e., disorders identified in the DSM) can improperly be used to reinforce negative social beliefs (Hozid, 2013), including stereotyping and microaggressions. Clients are seeking counseling services for sexual issues (Ayres & Haddock, 2009; Goldberg et al., 2008; Harris & Hays, 2008; Bloom et al., 2016), but counselors might be holding conservative and/or progressive beliefs about sexuality (Authors, 2016) that inhibit their unbiased treatment of those problems, thus impairing their ability to fulfill their role as an ethical counselor working within their boundaries of skills and competence (ACA, 2014).

A review of the literature indicates that counselors' comfort with sexuality might be a mitigating factor in the treat-

ment of sexual issues (Kazukauskas & Lam, 2009; Harris & Hays, 2008; Bloom et al., 2016). Goldberg and colleagues (2008) explored marriage and family therapists' (N = 134) treatment of client issues related to cybersex and identified that 20% of their sample did not feel prepared to diagnose problems related to cybersex. Similarly, Ayres and Haddock (2009) examined marriage and family therapists' (N = 99) treatment of client issues related to pornography use and reported that 47.4% of their sample did not receive training as graduate students about pornography use, and 79% of their sample felt "minimally" or "not at all" trained to work with clients related to those issues (p. 63). Harris and Hays (2008) also explored marriage and family therapists' (N = 175) comfort with sexuality and identified that therapists who received more training and/or attained supervision were more comfortable discussing issues of sexuality with clients, supporting the call for increased discussion and availability of resources to increase counselors' comfort with sexuality.

Bloom et al. (2016) explored counselors' (n = 575) comfort with sexuality and attitudes towards pornography and identified that both variables were predictive of counselors' assessment and treatment of clinical issues related to client pornography use. Authors speculated on their data in conjunction with exploratory questions from their investigation and noted, "We believe that confidence to treat issues related to sexuality might predict counselors' comfort with working with clients, and we believe that counselors' quality of training influences their confidence to treat issues of sexuality" (p. 339). Furthermore, they identified a subsample of counselors from their study (n = 79) who viewed pornography "to learn about sexuality" (p. 334), further highlighting the need for counselors' formal education on sexual practices.

In light of Bloom et al.'s (2016) study in addition to the existent literature on counselors' comfort with sexuality, counselors could benefit from a model guiding their treatment of client sexual issues, which might enhance their confidence and competence in working with clients with those presenting issues. With the understanding that sexual values and practices vary per individual and per sexual relationship (Yarber, 2013), it is to remember the importance for counselors to do no harm (ACA, 2014) by not pathologizing their clients (Hozid, 2013). Therefore, we call for counselors to infuse a wellness-informed approach in their work with clients regarding issues of sexuality. Thus, in alignment with the counseling professions' strengths-based stance towards sexuality (Burnes et al., 2017), we offer the SVBDM as an atheoretical approach that can be integrated into any counselor's clinical work as a way to assist clients in reducing discrepancies between their beliefs and values about sexuality and their sexual behaviors.

## Theoretical Foundations

To meet the needs of diverse clients presenting to counseling with nuanced issues related to their sexuality, and in order to provide a general strategy that can be integrated into most counselors' orientations, we based the SVBDM on relationship-oriented principles (Rogers, 1957). As such, we also recognize the importance of a building and maintaining a counselor's level of differentiation (Bowen, 1993) in order to facilitate a client's growth. Finally, we encourage a holistic and strength-based conceptualization of clients and their presenting issues. The following sections delineate these concepts.

### Therapeutic Relationships and Differentiation

Across theoretical approaches (Corey, 2016), most counselors infuse three therapist-led core conditions into their clinical work, as originally outlined by Rogers (1957, 1980): unconditional positive regard, empathy, and congruence. Researchers have established the essential role that therapeutic relationships play in the creation of positive client outcomes (Lambert & Bergin, 2001; Norcross, 2011; Norcross & Lambert, 2011). Indeed, the therapeutic relationship is predictive of positive client outcomes (Connors, Carroll, DiClemente, Longabaugh, & Donovan, 1997; Krupnick et al., 2006), accounting for about 30% of the variance (Lambert & Barley, 2001). Consequently, it is necessary for counselors to facilitate a strong working relationship with their clients.

In addition to the establishment of a therapeutic relationship, counselors also need to maintain the therapeutic relationship by avoiding therapeutic ruptures, and tending to ruptures in the relationship when they happen (Norcross & Lambert, 2011). Generally, a rupture might occur in the therapeutic relationship if a counselor is no longer congruent with themselves, when positive regard becomes conditional, or if the counselor is unable to remain in psychological contact with the client due to a potential reaction to the content or process occurring in session (Norcross & Lambert, 2011; Rogers, 1957).

Murray Bowen (1993) recognized negative reactivity and anxiety as potential factors interfering with the ability to maintain one's sense of self (i.e., to be congruent), or to be differentiated, thus impacting the therapeutic relationship. In this way, Bowen's concept of differentiation speaks to an individual's ability to regulate one's self in the presence of another person's emotional space, belief, and/or value system. While differentiation was conceptualized regarding individuals (i.e., clients) in a relational context, Bowen and other scholars also recognized the essentially that counselors also need to possess high levels of differentiation (Heiden-Rootes et al., 2017; Schnarch, 1991; Siegel, 2010). Thus, an essential component of the SVBDM is a counselor's reflection in order to better understand their points of reactivity and/or

limitations when working with clients regarding sensitive or emotionally provocative subjects (e.g., sexuality). Overall, in order for a counselor to address a client's experience of sexual wellness, a counselor must be able to promote and maintain a strong therapeutic relationship and work within their boundaries of competence. In doing so, counselors may be more likely to successfully provide a general platform for clients to discuss discrepancies between their sexual wants, values, and practices, in conjunction with any other presenting clinical concerns.

### Wellness-Informed Counseling & Wellness Discrepancies

In addition to the importance of integrating the core conditions and differentiation into a counselor's repertoire, the concept of wellness is an essential platform when conceptualizing client concerns. Alfred Adler was the first theorist to emphasize the importance of an individual's experience of wellness and proposed the term "Gemeinschaftsgefühl," which translates to community. Since his formative work, wellness has been tied to this concept of community or social interest (Adler, 1954). Scholars transitioned from Adler's traditional conceptualization of social interest towards a definition of social wellness in terms of an individual's relationship to the environment and others (Hettler, 1980). Definitions of social wellness continued to evolve, promoting personal relationships while deemphasizing external (environmental) components (Adams, Bezner, & Steinhardt, 1997). Though different definitions of social wellness exist, many wellness authors (e.g., Adler, 1954; Hettler, 1980; Myers, Luecht, & Sweeney, 2004; Myers & Sweeney, 2005; Wither & Sweeney, 1992) agree on the importance of social relationships. For this reason, we infuse wellness within the SVBDM model so that client concerns are viewed within a strengths-based paradigm; supporting the idea that sexuality can be both personal and social in nature (Roach & Young, 2007). The infusion of a holistic, strength-based approach aids in mitigating against potential harm done by inadvertently pathologizing clients through a medical model lens (Barden, Conley, & Young, 2015) and aligns with the counseling profession's background and current values.

Despite its varied conceptualizations, wellness is defined as an individual's overall experience of physical, mental, and emotional health across the lifespan (Diamond & Huebner, 2012; Mosher, 2017; World Health Organization, 2010). This holistic conceptualization of a client aligns with the counseling profession's promotion of well-being and optimal functioning across a plethora of bio-psycho-social paradigms (Burnes et al., 2017). Though holistic wellness is paramount, as people are constantly striving towards optimal functioning, the understanding and use of wellness discrepancies within the counseling process is equally essential in the work of counselors. In relation to sexuality specifically, previous wellness models included sexual intimacy or sexuality fac-

tors (Witmer & Sweeney, 1992); however, none explicitly focused on the importance of clients' sexual values or examined the discrepancy between their perceived sexuality and ideal sexuality within the conceptualization and treatment process. Any discrepancies can be informative to the counselor as to where the presenting issue may lie, as opposed to relying singularly on DSM diagnoses. The latter may perpetuate biases and/or misunderstandings of gender and sexuality identity. Therefore, counselors can utilize clients' wellness discrepancies, particularly sexual wellness, to promote insight for the client on their perceived self and ideal self, promoting congruence of self.

Consistent with Carl Rogers' (1957) emphasis of promoting a client's experience of congruence, some wellness researchers (Blount & Lambie, 2017) promote a strengths-based conceptualization of clients' presenting concerns in light of discrepancies between ideals and practices. Thus, if an individual's perceived sexuality (i.e., sexual practices, values) is different from their aspirational/ideal sexuality (i.e., desired sexual practices, values), a discrepancy exists which could cause a rift in the client's well-being (Blount & Lambie, 2017). Similarly, if a client strives toward congruence between their sexual values (i.e., what the client perceives they want in relation to their sexuality) and their sexual behaviors (i.e., the actions the client is taking in regard to their sexuality), then they are more likely to feel content in that area of wellness. In total, for the creation of the SVBDM, we considered individuals' dynamic identity and expression of sexuality (Yarber, 2013), potential areas for counselors' experience of countertransference (Heiden-Rootes et al., 2017), the call for counselors' assessment and treatment of sexual issues (e.g., Goldberg et al., 2008; Bloom et al., 2016), and sound integration of theoretically supported principles that can be adopted into any counselor's general practice.

### The Sexual Values and Behaviors Discrepancy Model

We created the SVBDM to provide counselors with a concrete order of operations to follow when working with clients to address their issues related to sexuality. The purpose of the model is to potentially increase counselors' sense of comfort and/or confidence to assess and treat clients for those issues while simultaneously providing a series of steps (see Figure 1) to assist counselors in recognizing the boundaries and limitations of their professional competence.

In step one, the counselor works with their client to co-create working definitions of the client's ideal and actual sexual values and practices. Simultaneously, in step two, the counselor reflects on their reactions to their client, the content of the session, and potential areas for their own growth through consultation, supervision, and/or additional training. Lastly, in step three, the counselor works with the client to reduce discrepancies between the client's ideal and practiced values and behaviors while also assessing for any potential

safety issues (e.g., high risk sexual behaviors; consent) that might affect the client. The following sections further delineate the components for each step of the SVBDM.

### Step 1: Identification and Operationalization of Potential Sexual Issues

Researchers call for increased opportunities to assess for issues related to sexuality (Burnes et al., 2017; Hook, 2007; Watkins, 2008). Therefore, we follow Bloom et al.'s (2016) suggestion to create space in an intake session for clients to discuss their sexuality. Specifically, a counselor might leave a space on an intake questionnaire for the client to circle "yes" or "no" in response to a question that asks, "Have you or a friend or a loved one been concerned about your sexual activity?" Further, we encourage counselors to rely on their basic counseling skills (e.g., open-ended questioning, reflection of content, reflection of feeling, summarizing) to continue to explore any identified issue. If the counselor is unfamiliar with the term or issue identified by the client, we suggest the counselor ask non-invasive follow-up questions to clarify what the client's issue is, even going as far as to co-create a definition of the presenting issue. For example, a client might report that they feel guilty for "cheating" on their partner by pursuing relationships online, even if they have not met any of those individuals in person. Thus, a counselor might ask the client, "What constitutes cheating, and what doesn't?" As such, the client and counselor might co-create, lead by the client, a working definition of "cheating" to mean pursuit of emotional relationships that feel non-platonic, even if they do not include physical contact. It is our hope that by creating an opportunity to ask about sex or sexuality and having conversations regarding sexuality, clients might feel more encouraged to be open about any presenting concerns that might be related to their sexuality.

It is necessary for the counselor to consider four domains of assessment in this step, including assessment of the client's (1) current and (2) ideal beliefs or values as well as assessment of their own (3) ideal and (4) practiced behaviors. Regarding the client's ideal and current beliefs or values, we recommend counselors reflect discrepancies between what the client currently believes or values and what they would ultimately like to believe or value. For example, a client might report that they believe that sex is a meaningless act (i.e., current belief), but the client wishes that they could experience a meaningful sexual connection with a partner (i.e., ideal value).

Alternatively, a client might come to therapy with a presenting behavior that they currently practice that they wish to change. Regarding the assessment of a client's ideal and practiced behaviors, it is necessary to note what the client is currently doing. For example, a client might report that they want to reduce the amount they masturbate on a daily basis. We recommend that counselors work in this step to quan-



### Sexual Values and Behaviors Discrepancy Model

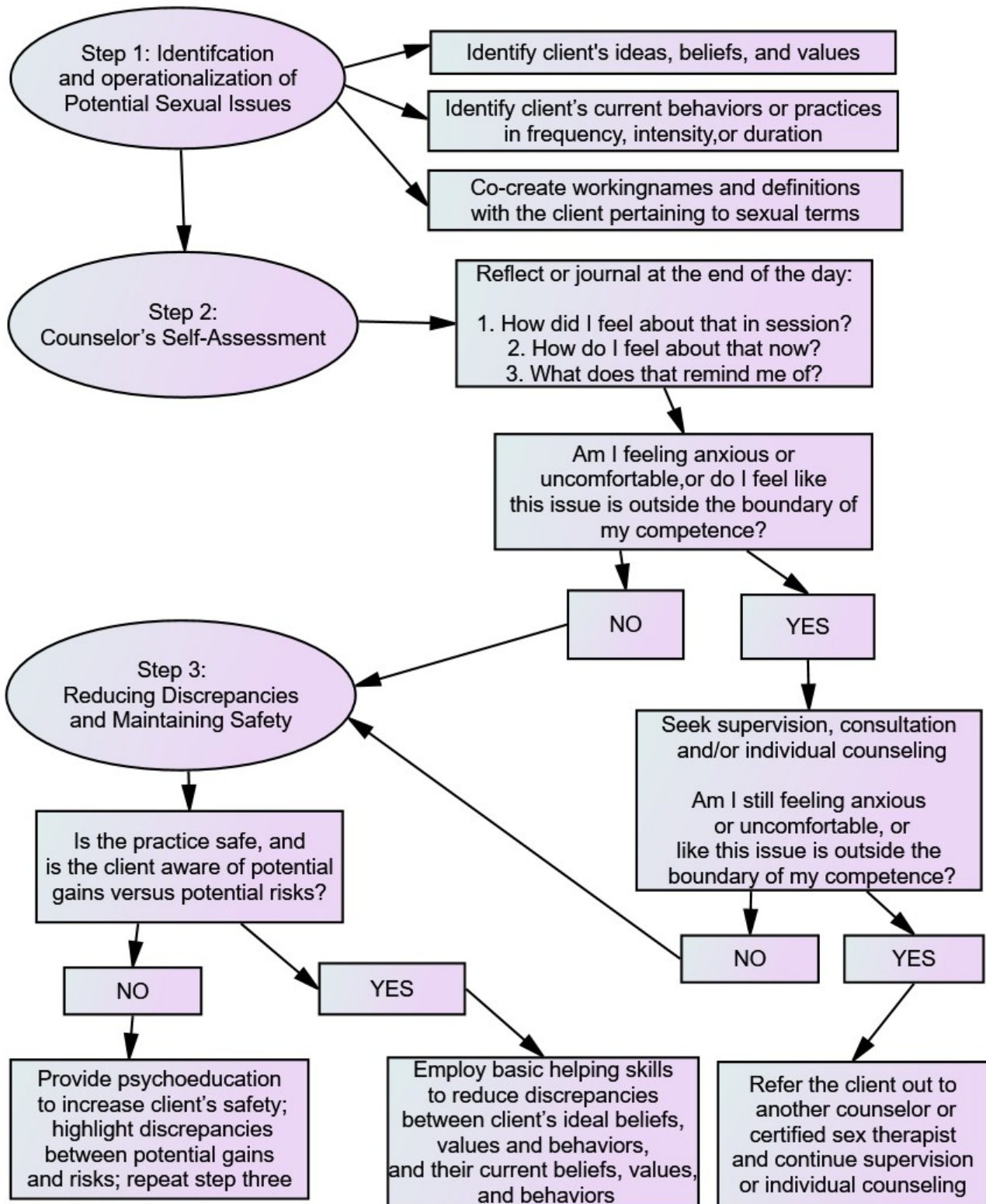


Figure 1. Sexual Values and Behaviors Discrepancy Model

tify the client's ideal beliefs or values and ideal behaviors as well as their current beliefs or values and practices. We suggest counselors explore client behaviors in measures of frequency and duration. Considering the previous example, a client might report that they masturbate an average of three times per day and they want to reduce that frequency to one time per day on average (i.e., frequency). Alternatively, the client might report that they masturbate for two hours per day on average and would like to reduce that amount of time to a half hour per day on average (i.e., duration). Consequently, step one might require counselors and clients to continually revise a co-created definition of the problem as more information is gathered.

While beliefs and values can be more difficult to quantify, we suggest using scaling questions to evaluate the client's intensity of their belief or value. Considering the previous example of a client who wants to experience partnered sexual activity as more meaningful, a counselor might use scaling questions to assist the client in identifying that sexual activity currently feels like a "3" on a 10-point scale, where 10 represents high levels of meaning, and the client wants to experience partnered sexual activity as a "7" or higher. With this strategy, a counselor can assist the client in setting more objective goals and measure progress or stagnation towards meeting those goals.

While step one regards information gathering, it is necessary to note that behaviors are influenced by clients' beliefs and values, and exploring their beliefs and values that influence practiced or ideal behaviors is an integral part of the SVBDM that will be discussed in step three. Overall, the purpose of step one is to ensure that a counselor and client can speak the same language to understand what the client is currently experiencing in beliefs or values and behaviors and what they would like to experience instead. Consistent with Blount & Lambie (2017), we believe that sexual wellness is likely to be achieved by low discrepancies between current and ideal practices/values; and areas for growth involve high discrepancies between current and ideal practices/values. Therefore, the counselor can utilize information gained in step one to reduce discrepancies between the client's ideal and current

## Step 2: Counselor's Self-Assessment

The SVBDM is a reflective model, and we believe it is especially important for counselors to provide a safe and supportive environment in the counseling process due to the sensitive nature of sexuality. Therefore, we call for counselors to consider strategies to evaluate their own limitations in regard to their work with clients presenting to counseling with sexual issues and to make appropriate referrals to other professionals as necessary. While it is imperative for counselors to work within their boundaries of competence, we note that referrals to other professionals can be harmful for clients –

especially after a client has made a potentially sensitive disclosure or has previous experiences of rejection – and referrals should only be considered as necessary when all other professional interventions have failed (e.g., supervision, additional training/education).

The second step of the SVBDM is for counselors to take a personal inventory of their beliefs, values, and experiences that might generate countertransference issues, negative reactivity, or anxiety regarding the client's presenting content (i.e., low differentiation). For example, a client who reports that they are engaging in extramarital relationships might trigger a counselor to feel angry with the client if the content relates to the counselor's previous experiences of infidelity in their relationship history. Or, perhaps the subject of infidelity might make it difficult for the counselor to maintain unconditional positive regard if it goes against personal values of fidelity. Regardless of whether the counselor's reactivity is due to countertransference or possessing values different from the client's values, it is necessary for the counselor to take ownership of their reactivity and to take steps to reduce it (i.e., increase differentiation).

Ideally, we would recommend that counselors assess their reactivity simultaneously while working in session with the client. However, we recognize that discussion of sexual issues might be overwhelming to some counselors as documented in previous research (e.g., Bloom et al., 2016). Thus, counselors might be better able to serve their clients by setting aside some time at the end of their session or workday to think about the content reported in session and to ask themselves, (1) "How did I feel about that in session?" (2) "How do I feel about that now?" and (3) "What does that remind me of?" Further, it is important for a counselor to evaluate, "How do I feel about people who want or do the things described in session?" If possible, we encourage counselors to write a journal response to these questions and then evaluate their own responses to determine if they are experiencing any anxiety or countertransference regarding the client, the process of working with the client, or the content of what was reported in session.

We suggest that if counselors are experiencing discomfort or anxiety, that they seek supervision and consultation to determine whether their work with the client is in the client's best interest (ACA 2014). For example, through supervision or consultation, a counselor with the support of a supervisor might recognize that it would be beneficial to seek individual counseling for their discomfort with discussing the client's presenting issue. While exploring countertransference issues with another therapist, the counselor can make a more informed decision as to whether or not they can appropriately and ethically continue to work with the client, again understanding that referring a client to another therapist is not an ideal outcome.

Furthermore, we suggest that counselors also explore how

knowledgeable they feel about the presenting issue. If the counselor feels comfortable working with the client regarding the presenting concern, but uncomfortable with their knowledge on the subject, the counselor could pursue supervision and/or consultation to determine how they can learn more about the issue (e.g., additional training or continuing education opportunities). For example, it might benefit the counselor to meet with an educator through the American Association of Sexuality Educators, Counselors and Therapists (AASECT) to further assist the counselor in developing their knowledge and skills. We believe that counselors can address sexuality-related issues as they do for more common presenting issues (e.g., anxiety, depression) by relying on their basic skills paired with their theoretical orientation; it is important that counselors do not shy away from this work and confuse feelings of discomfort with a lack of skill. We are hopeful that through supervision or consultation, the counselor could continuously gauge whether or not they are able to work with the client within their boundaries of competence, or if it might be more beneficial for the counselor to refer the client to a specialist (e.g., a certified sex therapist). For example, if a counselor is working with a couple where one partner is experiencing pain during sex (e.g., Genito-Pelvic Pain Disorder), and the counselor is unfamiliar with the nuances of the diagnosis or corresponding treatment protocol, the counselor is encouraged to refer the couple to a sex therapist. We hope that counselors who take an opportunity to assess their own discomfort will be empowered to make more informed decisions for themselves to best serve their clients. In summary, step two is labeled "Self-Assessment," and it is intended as an opportunity for counselors to review their beliefs and values surrounding sex and sexuality to identify potential countertransference issues with clarity.

### **Step 3: Reducing Discrepancies and Maintaining Safety**

After the counselor has worked with the client using shared language to identify a sexual belief or value or behavior that the client would like to address in therapy (Step 1), and the counselor has determined that they are working within their boundaries of competence to address the presenting issue without countertransference or value interference (Step 2), we recommend that counselors assist their clients in identifying discrepancies between their current beliefs or values and practices and their ideal beliefs or values and practices. It is necessary to note that beliefs and values – like behaviors – are influenced by additional factors. In this way, we hope the counselor works with the client to explore factors that might influence the client's beliefs or values, such as social messaging, religious ideals, modeled behavior, previous trauma, or intergenerational family patterns. We hope the open nature of the model allows counselors to pursue factors that are especially important or relevant to the counselor's theoretical orientation.

As part of this process, it might also be helpful to recognize potential interactions between a client's beliefs or values and their behaviors. Clients who present with a behavioral goal might be unaware of how their behavior could be a manifestation of a belief or value. Therefore, exploring the beliefs or values compelling a client's practiced or ideal behavior could help the client to better identify their goals for counseling. As an example, if a client presents to counseling and reports that they want to stop masturbating, it might be helpful to explore the client's motivation for their goal to better understand their pursuit of it. In this example, if the client wants masturbation to not interfere with their sexual activity with their romantic partner, the counselor and the client can work together to deconstruct the influence of the client's values on their behavioral goal. A solution-focused therapist might assist the client in identifying exceptions to the problem, and the issue might be resolved by the client's increased awareness that their masturbation practices have not yet interfered in their sexual relationship with their romantic partner, and they do not need to abstain from masturbation.

Following the SVBDM, if a client presents for counseling services and reports that they feel guilty for cheating on their partner through online relationships, the counselor can work with the client to identify specific, measureable, and objective behaviors that the client is practicing (e.g., chatting online with non-platonic partners for two hours per day) and specific ideals and values the client possesses (e.g., "I should only flirt with my partner," or "I should only find my partner attractive"). Then, the counselor can work with the client to identify the ideal behavior and value they would like to possess. For example, the same client might report "I wish I wouldn't chat with anyone at all!" or identify "I wish I believed that I could flirt with other people as long as I only engage in physical intimacy with my partner." In accordance with step two, we hope the counselor examines their reactions to the client, the content of the session, and any potential areas for countertransference both in the session and reflectively after the session. Assuming the counselor does not find any issues to address in consultation or supervision and that the counselor believes they do not need to seek further educational opportunities or training on the subject of the client's presenting issue, the counselor can begin to work to reduce the client's perceived discrepancies.

Just as in the assessment process of step one, we recommend counselors rely on their basic counseling skills (e.g., reflection of content, reflection of feeling) and other techniques from their preferred theoretical orientation in the process of reducing discrepancies. For example, a psychodynamic counselor might explore a client's relationships with members of their family of origin to identify parallels and patterns that are present in their romantic relationship. Similarly, an Adlerian therapist might use an open-ended question (e.g., "how was fidelity modeled for you by your parents' re-

lationship?”) to explore a client’s early recollections and their influence on the client’s private logic. Or, an existential therapist might use Socratic questioning (e.g., explore complex ideas, uncover assumptions, analyze concepts) to deconstruct the client’s value system.

While the SVBDM serves as a guiding tool for counselors to facilitate client change between ideal and practiced beliefs or values and behaviors, counselors must also consider whether the client’s goal(s) for therapy might be best achieved by altering the current beliefs or values or practices or by changing the ideal beliefs or values or practices. While it might make sense to imagine that counselors should work to help clients move towards their ideal beliefs or values and practices, some clients may present to counseling with unrealistic ideals. As an example, if a client presents to counseling with a stated goal of stopping sexual activities with same-sex partners and a stated interest in pursuing exclusively heterosexual relationships, counselors must recognize that the client might be struggling with their sexual identity and that conforming to heterosexual ideals might not be in the client’s best interest. Thus, a counselor following the SVBDM must consider that an appropriate counseling goal might be for a client to deconstruct their ideal beliefs or values and practices in order to better find acceptance of one’s current beliefs or values or practices. At the same time, it is also important for a counselor to recognize that a client might make behavioral choices (e.g., abstinence from sexual activity with same sex partners) in order to adhere to their belief system, even if it is inconsistent with what appears to be the client’s sexual orientation. For example, a male Muslim client who is attracted to other men might choose to not engage in same sex relationships in order to be consistent with their religious beliefs. In that way, it is important for the counselor to explore the interaction between the client’s beliefs, values, and behaviors, to establish realistic, attainable, and therapeutic goals for the client. As it relates to this example, we call for counselors to accept clients’ choices that are determined by the client as best for them at that time, so long as their choices are safe.

In the spirit of promoting wellness while preventing harm (American Counseling Association, 2014; Council for Accreditation of Counseling and Related Educational Programs, 2016), we recommend that counselors also assess for safety while gathering information pertaining to the client’s current and ideal practices and values. For example, if a client reports that they engage in unprotected sex with anonymous partners and the client appears to be unaware of risks that are associated with that behavior, the counselor could provide psychoeducation to the client as a way to reduce potential harm as a result of sexual violence, unintended pregnancy, or sexually transmitted infections. More specifically, the counselor is encouraged to address the client’s perception of what might be gained or lost by continuing those behaviors, again aiming to reduce the discrepancy between

what the client wants (e.g., empowered sexual expression) and what the client is doing (e.g., increasing risk and opportunity for potential harm). The counselor is encouraged to discuss the ideal practice and co-create a safer practice for the client.

Because no catalogue exists that delineates safe and unsafe behaviors for a client to practice, we recommend that discussions around safety are ongoing between the counselor and the client, as they work collaboratively in the client’s best interest. This process might be unique to each client, especially as it relates to their individual sexual practices and community membership. Discussions regarding safety might extend to discussions around consent, “coming-out,” or referrals to medical doctors to diagnose a client’s reported physical symptoms. Overall, assessment of safety and education – for both the client and the counselor – are on-going components of the model and are especially relevant in the assessment of current and future sexual ideals and practice.

We believe that one of the greatest strengths of the SVBDM for counselors is its adaptability to various theoretical orientations and practices. Therefore, we encourage counselors to rely again on their basic counseling skills (e.g., paraphrasing, confrontation) and use of Socratic questioning to highlight discrepancies between the client’s current and ideal practices and values. However, we encourage counselors to operate from the theoretical orientation that resonates for them in their clinical practice. Further, we believe the model can be utilized with diverse clients and can be tailored for work across cultures/belief systems because the SVBDM calls for counselors to explore and honor a client’s worldview. As such, we encourage culture and background to be considered when evaluating the clients presenting issue in counseling, and suggest counselors continue to assess current and future practices as safe, while taking steps to mitigate against unsafe practices (e.g., psychoeducation).

## Conclusion

To our knowledge, the Sexual Values and Behaviors Discrepancy Model (SVBDM) is the first model intended for use by counselors to comprehensively address individuals’ dynamic identity and expression of sexuality (Yarber, 2013), potential areas for counselors’ experience of countertransference (Heiden-Rootes et al., 2017), the call for counselors’ assessment and treatment of sexual issues (e.g., Goldberg et al., 2008; Bloom et al., 2016), and sound integration of theoretically supported principles that can be adopted into a counselor’s general practice. Counselors are encouraged in their implementation of this model to self-reflect frequently while working with clients who present with sex or sexuality concerns, to approach clients consistently with the core conditions to create and maintain safety within the therapeutic relationship, and to pursue specialized training for areas of specific interest. We recommend counselors utilize steps one

and two simultaneously (e.g., information gathering and self-reflection) throughout their work with clients. By means of consistent self-reflection, counselors may become aware of biases, concerns, or limitations of knowledge prior to working with a client rather than during the initial intake. We are hopeful that during this process, counselors are aware of their blind spots and limitations prior to accepting clients that are beyond the scope of their expertise. We believe one of the strengths of this model is in its orientation and focus on client safety in sexual practices and behaviors, which can be clouded by a counselor's judgments or beliefs about a client's perceived and ideal practices.

Through the review of current literature, we addressed the counselors' need for increased skill, knowledge, and comfort with discussing issues related to client sexuality by offering a general model for counselors to incorporate into their practice. We also encourage CACREP (2016) to consider the addition of new standards that would require counselor education programs to offer a course in human sexuality, as sex and sexuality concerns are common in client presenting issues (Ayres & Haddock, 2009; Harris & Hays, 2008; Kazukauskas & Lam, 2009; Sanabria & Murray, 2018; Bloom et al., 2016). This model might be a useful tool to be included in a human sexuality course as a way to assist students early in their clinical training to understand the importance of assessment and self-reflection in their work with clients. Therefore, we hope counselor educators can use this model as a step by step process to follow in clinical case studies and in role play situations with counselors-in-training.

Although this model is grounded in empirical research, it has yet to be tested. We call for future researchers to test counselor efficacy using this model in regard to the assessment and treatment of client issues related to sexuality. Further, this model is focused on clients' report of how they are feeling or behaving and how they desire to be feeling or behaving. Although we recommend that counselors use their clinical judgment in step 3 to consider the appropriateness of ideal values or beliefs, this current model does not specifically assess how adaptive or positive the clients' beliefs, values, or behaviors are. Future editions of this model might include a sexual health assessment in order to manage healthy versus risky behaviors as well as assess the client's sexual functioning (mitigating the self-report nature of the model). In addition, researchers can explore comfort and confidence of counselors who implement this model on sexuality/sexual issues versus those counselors who do not use a model as a point of reference. To enhance use of this model, we encourage future researchers to develop an assessment of counselor comfort and knowledge of common sexual and sexuality concerns for counselors to use within their self-reflection (i.e., step two).

In conclusion, clients present to counseling with sexual issues regardless of counselors' expertise. Researchers have

noted consistently that counselors' feelings of discomfort or lack of preparation regarding sexual and/or sexuality concerns might be mitigating factors in the assessment and treatment clients' sexual issues (Bloom et al., 2016). Therefore, we developed the SVBDM as a reflective model for counselors to follow to assist their clients in safely reducing discrepancies between their ideal and practiced sexual values and behaviors.

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# The Use of Technology in Sexual Exploration Among a Rape Culture Youth

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The present investigation sought to address the gap of research surrounding rape myth acceptance attitudes and cyber-sexual assault (CBSA). Researchers examined data collected from a college sample of 94 undergraduate psychology students. The purpose of this investigation was to explore whether this sample of college students reported any potential stereotypes pertaining to cyber-sexual assault victims and whether the college students utilized technology for sexual exploration (e.g., creation, distribution, and receiving of sexually explicit material). In addition to identifying cyber-sexual victims, this study explored the correlation of gender with those responses. Results are reported, and suggestions for counselors are offered. The researchers hypothesize that rape culture acceptance attitudes have shifted to victims of online abuse, though more research is warranted to draw specific conclusions.

*Keywords:* cyber-sexual assault, revenge-porn, sexual violence, rape culture, college students

## Introduction

The United States is the lead consumer of technology, and recent advancements have shifted the way we communicate (Marganski & Fauth, 2013). This evolution of technology-facilitated conversations has transformed how individuals engage, which currently occurs most often through the avenues of cell phones, text messaging, and social media. Today, almost 85% of Americans own cell phones (Marganski & Fauth, 2013), and nearly two thirds to three-quarters of cell phone users regularly send and receive text messages (Kohut et al., 2011; Smith, 2011). As anticipated, text messaging is now the preferred means of communication among young adults (Marganski & Fauth, 2013; Smith, 2011). Moreover, social media is a widely used platform among young adults, where some youth have reported being online "constantly" (Anderson & Jiang, 2018). In fact, students spend nearly an hour on Facebook daily, as nearly 50% of students had logged onto their social media accounts multiple times throughout the day (Anderson & Jiang, 2018; Sponcil & Gitimu, 2013). With the rise and expansion of technology, cell phones (e.g., text messaging), internet use, and social media sites have become the socially favored route of communication among peer groups. In light of this surge in technology usage among youth, communication researchers (Armstrong & Mahone, 2017) pointed out that such avenues have extended how material is distributed, which includes sexually explicit material.

Cyber-sexual assault (CBSA), also known as "nonconsensual pornography" or "revenge porn," is the nonconsensual sharing of sexually explicit images online, through social media avenues like Facebook and Instagram (Holladay,

2016). Specifically, CBSA refers to the dissemination of sexually explicit images where one of the pictured individuals did not consent to the distribution of the material (Bartow, 2012; Bloom, 2016)). For example, the material can be posted by an ex-lover upon the ending of a relationship in efforts to taunt or humiliate the victim (Laird & Toups, 2013). The definition of CBSA can also encompass other nonconsensual distribution of intimate photographs, whether by a classmate or roommate, in efforts to bully or harass the victim (Bartow, 2012). Victims of CBSA can be shamed into silence when these private photos are made accessible for viewing by family members, friends, employers, schools, social media networks, and more. Further, the sexually explicit images can be posted on hundreds of websites, almost instantly, resulting in one Google search of the pictured individual's name being overrun with the images (Citron & Franks, 2014; Bloom, 2016).

The mental health consequences associated with cyber-sexual assault are largely unknown. Recent quantitative (Holladay, 2016) and qualitative (Bates, 2016) literature

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identified constructs (e.g., depression, suicidal thoughts, emotional dysregulation, post-traumatic stress) common among sexual assault survivors for two smaller samples of CBSA survivors. Despite this, as of now, CBSA is not classified as a form of sexual assault due to the lack of research, leaving victims with limited options for mental health care, while also leaving clinicians with no efficacious treatment approaches. Furthermore, prevalence rates have been difficult to measure, because a victim's speaking out can exacerbate the assault (Citron & Franks, 2014). An invaluable research contribution, however, has recently identified that one in 25 Americans have been harassed with their sexually intimate photos or become victims of CBSA (Data & Society Research Institute & the Center for Innovative Public Health Research, 2016). Meanwhile, researchers (Drouin, Vogel, Surbey, & Stills, 2013) reported that 55% - 78% of individuals have engaged in sexting, or the sharing of sexually intimate material through technology. With such high prevalence rates for engaging in the creation and distribution of personal, sexually intimate material, we wondered what the prevalence rates were for those that blame victims who are harassed with their sexually explicit material. In a recent study that examined biases towards blaming rape victims (Felson & Palmore, 2018), the researchers found that college students were more likely to engage in indirect blame; however, the researchers' also noted that college students were willing to use the word blame if they perceived a person's own recklessness as having led to their misfortune (e.g., assault). Because cyber-sexual assault survivors participated in the creation of their material (in some cases), we wondered if survivors of cyber-sexual assault would experience increased levels of blame surrounding their assault?

This investigation was specifically tested for behaviors of college students' in the creation, dissemination, and reception of sexually explicit images. Additionally, we explored the participants' responses concerning those individuals who become victimized with their private, sexually explicit images. Lastly, we explored the relationship of gender based on the participants' responses. Overall, this study served to initiate the conversation surrounding current rape culture attitudes, and how these may manifest through the proliferation of CBSA. With this in mind, we first present current research on the use of technology with sexual exploration among young adults (e.g., creation and sharing of sexual material). This section includes literature on deviant behaviors and the nonconsensual sharing of another person's private, sexual material. We conclude with how CBSA perpetuates rape culture acceptance attitudes.

### **Young Adults and Technology: When Sharing Intimate Images Digitally Goes Awry**

An online cultural revolution has changed the way we interact both socially, and sexually. Sexting refers to the self-

creation (e.g., selfie) and the digital sending of a sexually explicit image, which is next transmitted through email, social media, or cellphone (e.g., text message). Typically, the individual shares their private image digitally, with a romantic interest or partner (Humbach, 2014; Henry & Powell, 2014b). Due to the nearly immediate transmission of information online, images can be disseminated via technology quickly and broadly. Researchers (Henry & Powell, 2014a, 2015) have noted that the taking of sexual photos may be a sexually healthy form of sexual exploration in the new age of technology. One of the unintended consequences, however, can be a rapid and nonconsensual distribution of sexual photos; in these cases, the consequences for victims may be highly traumatic. Bloom (2016) noted that victims could spend their lives scrubbing their images from the web, across hundreds of websites, and due to the nature of the internet, those images may never be erased. The scope and frequency of CBSA, as highlighted above, encourages a social norm that sexual assault endured through technology is normal and the victims are to blame (i.e., rape myth acceptance; Holladay, 2016).

In a recent meta-analysis that reviewed 39 studies on sexting behaviors among youth (Madigan, Ly, Rash, Ouytsel, & Temple, 2018), some of the literature pointed to a rise of sexting behaviors for this population (60%). The researchers also pointed out that multiple youth (8.4% - 12.0%) had either forwarded or received a sexual image without the pictured individual's consent. This behavior could be due to rape myth acceptance attitudes (e.g., "they took the photo so they should expect it to be shared"). Conversely, it may stem from the anonymity of technology, which enables individuals to continue to forward nonconsensual intimate material, while emotionally separating themselves from the crime. Either way, the sharing of sexually explicit material with a partner (Bloom, 2016), and as a form of sexual exploration (Henry & Powell, 2015), is no longer atypical. Consequently, approximately 10% of individuals have been threatened with their sexually intimate photos, where among these threats 60% of individuals reported that their intimate material was eventually shared without their consent (McAfee, 2013). In fact, one in 25 Americans have been threatened with or have become victims of CBSA (Data & Society Research Institute & the Center for Innovative Public Health Research, 2016). This equates to nearly 10 million Americans, or 4%. Despite prevalence numbers indicating CBSA was on the rise, ninety-four percent of Americans believe that their intimate photographs are safe in the hands of their current partners (Bloom, 2016). In a national study (The National Campaign to Prevent Teen & Unplanned Pregnancy, 2008) exploring the sexting behaviors of teens and young adults, males and females reported the sharing of sexually intimate photos at nearly equal rates (young adult women, 36%; young adult men, 31%). However, this same study highlighted that the

young women were much more likely to experience pressure from their partner to send the sexually explicit photos in the first place, and that the young women were more likely to become victims of revenge porn (Bloom, 2016, Willard, 2010). Moreover, though victims of revenge porn are predominately female (Laird & Toups, 2013), it has been largely young males that run revenge porn websites (Laird & Toups, 2013; Morris, 2012). For instance, Hunter Moore, founder of an infamous revenge porn website, made national headlines after pleading guilty to charges for hosting a website

that contained women's stolen, naked photos online, where the victims were then charged a fee to remove the sexual material. In an interview titled "The Most Hated Man on the Internet" for the Rolling Stones, Moore was quoted saying, "I'm sorry that your daughter was 'cyber-raped,' but, I mean, now she's educated on technology" (Morris, 2012). In the case of CBSA victimization, Audrie Potts sadly made national headlines when she died by suicide after becoming the victim of revenge porn (Burleigh, 2013). Three boys took her clothes off while she laid in bed unconscious after partying, drew on her with sharpies, then took and disseminated sexually explicit pictures of her. Not long after being harassed with these images, Audrie Potts was found "dangling from a belt" by her mother (Burleigh, 2013). Previous studies have pointed to increased vulnerability to suicide (Holladay, 2016), where one study by the Cyber Civil Rights Initiative (2013) found 47% of survivors had contemplated suicide (Bloom, 2016).

Recently, more focus has been given to understanding the problematic depths of why young adults distribute another person's material (Boyd, 2007; Holladay, 2016) without regard for both copyrights and consequences (e.g., emotional or physical). Yet, little research has explored the healthy use of technology in a sexually consenting relationship, nor have researchers explored the implications of cyber-sexual assault in a rape prone culture. The goal of this preliminary study was to explore whether students utilize technology in sexual exploration, as well potential stereotypes pertaining to cyber-sexual assault. Audrie Potts completed her suicide not immediately after her nonconsensual photos were taken, but after being harassed by other classmates upon their release. As evidenced by suicidality post victimization, the rape myth culture that both tolerates and perpetuates CBSA as a cultural norm may have devastating consequences for victims. It is critical that researched claims guide mental health service providers towards an area of intervention when working with their clients, in this case victims of CBSA.

### **Cyber-Sexual Assault and the Proliferation of a Rape Myth Acceptance Culture**

Researchers have highlighted that technologically facilitated deviant sexual dating behaviors were among the rise for adults, nonetheless these continue to be minimized and disre-

garded (Marganski & Fauth, 2013; Huff, Johnson, & Miller, 2003). According to Huff et al.(2003) a physical component is necessary for a sexually based trauma to have occurred. CBSA refers to the dissemination of sexually explicit images where one of the pictured individuals did not consent to the distribution of the material (Bartow, 2012; Bloom, 2016), and may lack the physical component referenced by Huff et al. (2003). This perpetuates the rape myth acceptance attitudes that it is morally okay to humiliate someone online with their private photo since the abuse is not in a physical form.

Campbell, Dworkin, and Cabral (2009) asserted that we live in a rape prone culture that perpetuates a message that victims are to blame for their assault, and that such rape myth attitudes exist across cultural and social barriers. As noted by Reling et al. (2017), a vast amount of literature exists on how culturally normative sexual violence has become, proliferated by these rape culture attitudes. It is widely known among sexual violence researchers, that the likelihood a woman will experience sexual violence increases during college; approximately 1 in 5 (23.1%) college women have reported sexual assault (Cantor et al., 2015). Among a large-scale survey of 27 universities, 11.7% reported the experience of nonconsensual sexual contact while enrolled as a student (Cantor et al., 2015). Yet, what exactly is rape culture? In an article, "Rape Culture is Real" (Maxwell, 2014), the author reveals a few statements that we believed eloquently depicted the term.

Rape culture is when cyberbullies take pictures of sexual assaults and harass their victims online after the fact, which in the cases of Audrie Pott and Rehtaeh Parsons tragically ended in their suicides. Rape culture is when, in 31 states, rapists can legally sue for child custody if the rape results in pregnancy. Rape culture is when college campus advisers tasked with supporting the student body, shame survivors who report their rapes. (Annie Clark, a campus activist, says an administrator at the University of North Carolina, Chapel Hill told her when she reported her rape, "Well... Rape is like football, if you look back on the game, and you're the quarterback, Annie... is there anything you would have done differently?"). Rape culture is when women who come forward are questioned about what they were wearing. Rape culture is when survivors who come forward are asked, "Were you drinking?" Rape culture is when people say, "she was asking for it." Rape culture is when we teach women how to not get raped, instead of teaching men not to rape. (pp. 1-2)

The recent phenomena of CBSA can have a devastating

impact on victims' psychological well-being. This study serves to engage counselor educators and mental health clinicians on the topic, and explore trends surrounding college students and CBSA. We hypothesize that the lack of laws, research, and prevention programs constructs a social norm that sexual violence through technology is normal, and the victims are to blame. More specifically, the goal of this study was to explore the frequency with which college students are sexting, while also looking into the frequency of potential stereotypes pertaining to victims that are assaulted through technology, cyberspace, and social media.

### Methods

The current study explored behaviors of college students' and their creation, dissemination, and receiving of sexually explicit material. Additionally, we explored the participants' responses concerning those individuals who become victimized with their private, sexually explicit images. Lastly, we explored the relationships between genders and this sample of student's responses. We surveyed students at a midsize, public, southern university in the United States. For the present investigation, we used a panel of experts (i.e., doctors of counselor education; expert in survey design) to generate the instrument and we surveyed an undergraduate psychology course. This study was approved by the IRB at the University of Central Florida and all participants provided informed consent.

### Instrumentation Development

The instrument utilized in this investigation was constructed by a panel of experts, including an expert in survey design, and counselor education faculty members. The 19 items on the measurement (available upon request) were generated by the researchers following a rigorous literature review. The questionnaire, upon completion, was reviewed by these experts (counselor education faculty members and a statistician) for face validity. Following this, the instrument was administered to counselor education peers for clarity and legibility. This questionnaire was administered in-person to an undergraduate psychology course consisting of adult (age 18 and older) college students. The goal was to explore whether students utilize technology in sexual exploration, if they have ever been the victim of revenge-porn, as well as potential stereotypes held pertaining to cyber-sexual assault.

To increase the reliability of the survey answers, participants were provided with an explicit definition of revenge porn and sexually explicit prior to entering the survey. Revenge porn was defined as, "sexually explicit media that is publicly shared online without the consent of the pictured individual. Revenge porn is typically uploaded by ex-partners or hackers. The images are often accompanied by personally identifying information, like an individual's full name, social

media links, and addresses." Further, sexually explicit was defined as, "sexual content, usually depicting partial or full nudity of one or all individuals. Further, the material can be sexual in nature, used for purposes of arousal, with no nudity (e.g., lingerie)."

While previous instruments have identified prevalence numbers (2016), and methods for how nonconsensual material was shared (Eaton, Jacobs, & Ruvalcaba, 2017), there was a gap in the literature surrounding use of technology for sexual exploration and the correlation with rape myth acceptance attitudes towards cyber-sexual assault. Thus, we initially asked participants five questions that utilized a Likert scale, ranging from "strongly agree" to "strongly disagree." These questions were aimed at exploring CBSA related rape myth acceptance attitudes. Questions included statements such as, "if I took an intimate photo of my partner, I can do with it whatever I please;" and "victims of revenge porn should never have taken the photos in the first place." Following this, to explore the frequency of technology usage with sexual exploration, the scale utilized a dichotomous response type to learn whether the students had ever taken a sexually explicit photo themselves or allowed someone else to take their photo, had ever shared a sexually explicit photo with someone else, had ever unintentionally received a sexually explicit photo, or had ever been the victim of "revenge porn" or known someone who has, here described as cyber-sexual assault. We intentionally collected minimal demographics information (i.e., age, gender, ethnicity, sexual orientation, current relationship status, and college level) to preserve anonymity. At the end of the survey, participants were directed to campus resources that included a 24-hour source crisis hotline resource, as well as licensed therapist available on campus.

### Data Collection and Survey Administration

We collected the anonymous results from an undergraduate psychology course, on a southern college campus. To recruit participants, we attended an undergraduate psychology course in order to provide the survey in-person. All of the students were provided an informed consent and then the survey. Students that elected to participate in the study were instructed to complete the survey and return the hard copy in the envelope provided.

Approximately 169 individuals were invited to participate. This invitation yielded 56% response rate ( $N = 95$ ) for participants who had completed over 90% of the items on the instrument. We removed one individual who identified as transgender due to the research question surrounding gender differences, yielding a final useable sample of  $n = 94$ .

Utilizing the Cohen's  $d$  effect size of .64, the researchers calculated sample size post hoc. Thus, the researchers utilized a sample size calculator through [www.danielsoper.com](http://www.danielsoper.com), as recommended by Schumaker and Lomax (2010). An ob-

served Cohen's  $d$  of .63, with a probability level of .05, and a sample size of 94, resulted in the observed power (one-tailed hypothesis) of  $\beta = .917$ , and observed power for a two-tailed hypothesis was  $\beta = .855$ .

### Data Analysis

The data analysis utilized SPSS v.23. Participants were divided into two groups, based on self-reported gender. The researchers then explored the frequency of participants' responses to learn the influence of these in relation to CBSA rape myth acceptance attitudes, and their use of technology in the creation, dissemination, and receiving of sexually explicit material. Lastly, a Chi square was conducted to examine the relationship of gender and how the participants responded. Because only one individual identified as transgender, we could not include that participant in this particular study. A larger sample would need to be drawn, specifically targeting this population, in order to draw any representative conclusions.

## Results

### Participant Demographics

Descriptive data and measures of central tendency are presented for all participants (see Table 1) in the study ( $N = 95$ ). The following descriptive analyses reported include the entire sample ( $N = 95$ ; see Table 1). A large majority of participants were female ( $n = 65$ , 68.4%), compared to individuals who identified as male ( $n = 29$ , 30.5%) and other ( $n = 1$ , 1.1%). The majority of participants ranged in ages of 18-22 years ( $n = 80$ , 86.0%), followed by ranges 23-27 ( $n = 9$ , 9.7%), 28-32 years ( $n = 3$ , 3.2%), 33-37 years ( $n = 1$ , 1.1%). Regarding the ethnicity of participants ( $N = 95$ ) the sample was 52 (54.7%), mostly Caucasian/White, followed by 27 (28.4%) Hispanic/Latino, 6 (6.3%) biracial, 4 (4.2%) African/African American/Black, 4 (4.2%) Asian, and 2 (2.1%) Native Hawaiian or Pacific Islander. Sexual orientation of participants ( $N = 95$ ) was 80 (84.2%) mostly heterosexual; 11 (11.6%) bisexual; 1 (1.1%) gay/lesbian; and 3 (3.2%) other. Lastly, the majority of participants ( $N = 95$ ) were college senior's ( $n = 42$ , 44.2%), then junior ( $n = 36$ , 37.9%), sophomore ( $n = 14$ , 14.7%) and freshman ( $n = 3$ , 3.2%).

### Rape Myth Acceptance and Cyber Sexual Assault

When the students were asked, "if a couple is in a relationship it is normal to take sexually explicit pictures," the majority of women strongly agreed/agreed (53.8%), whereas a much lower amount disagreed and/or strongly disagreed (15.4%). Men also strongly agreed/agreed (48.2%) at nearly the same rate as the women. However, men disagreed/strongly disagreed (27.5%) at a much higher rate than the women. For both females (30.8%) and males (24.1%), a

Table 1  
Demographic Characteristics of Participants ( $n = 95$ )

Variable	n	%
Age		
18-22	80	84.2
23-27	9	9.4
28-32	3	3.1
33-37	1	1.0
Did Not Report	2	2.1
Gender		
Male	29	30.5
Female	65	68.4
Other	1	1.1
Ethnicity		
African American/Black	4	4.2
Asian	4	4.2
White (non-Hispanic)	52	54.7
Hispanic or Latino	27	28.4
Native Hawaiian or PI	2	2.1
Two or more races	6	6.3
Sexual Orientation		
Bisexual	11	11.6
Heterosexual	80	84.2
Gay/Lesbian	1	1.1
Other	3	3.2
Relationship Status		
Single	39	41.1
Dating	11	11.6
In a relationship	36	37.9
Cohabiting	6	6.3
Married	2	2.1
College Level		
Freshman	3	3.2
Sophomore	14	14.7
Junior	36	37.9
Senior	42	44.2

Note. AN = Alaskan Native, PI = Pacific Islander. Percentages may not equal 100% due to rounding

large portion reported they were undecided on this question. The relationship for gender with these responses was not significant,  $\chi^2(8, 94) = .630$ ,  $p > .05$ .

When the students were asked, "if I took an intimate photo of my partner, I can do with it whatever I please," the majority if women strongly disagreed/disagreed (86.2%); and for men, a substantial portion strongly disagreed/disagreed (62.0%). While a small portion of the women agreed/strongly agreed (4.6%), what was noteworthy was that a large portion of men strongly agreed/agreed (34.4%) with this statement. This equates to nearly one of three of the men in the study agreeing that they can do whatever they please with a sexually explicit image. Further, three times the number of females were undecided (9.2%)

when compared to males (3.4%) for this question. These frequencies were significant by gender,  $\chi^2(8, 94) = .051, p < .05$ , indicating that gender did influence whether participants agreed or disagreed with this question.

When the students were asked, "if a woman's naked photo ends up online, she deserves what she gets for taking the photo," the majority of women strongly disagreed/disagreed (83.1%) compared to women who strongly agree/agreed (10.8%). For men, the majority also strongly disagreed/disagree (65.5%); however, men strongly agree/agreed (24.1%) with the statement at more than double the rate of the women (10.8%). Even smaller number of females remained undecided (6.2%) than males (10.3%). The relationship for gender with these responses was not significant,  $\chi^2(8, 94) = .508, p > .05$ .

When the students were asked to respond to the statement that, "the social consequences of a woman's naked photos ending up online are more severe than those for a male's naked photos ending up online," the majority of women strongly agree/agree (72.4%), compared to those that strongly disagree/disagree (15.4%). For men, the majority strongly agree/agreed (48.3%), which was closely followed by the males that strongly disagree/disagree (37.9%). Both females (12.3%) and males (13.8%) remained undecided at nearly equal rates. These frequencies were significant by gender,  $\chi^2(8, 94) = .012, p < .05$ , indicating that gender did influence whether participants agreed or disagreed with this question.

When the students were asked to rate the statement, "victims of revenge porn should never have taken the photos in the first place," the majority of women strongly disagreed/disagreed (63.1%) compared to the women that strongly agreed/agreed (16.9%). The majority of men also strongly disagreed/disagreed (51.7%), while a large portion of males strongly agreed/agreed (27.6%). Thus, more than one out of four males reported that the victims should not have taken the intimate photo, compared to the one of six females that agreed with this statement. Again, both females (20.0%) and males (20.7%) remained undecided at nearly equal rates. The relationship for gender with these responses was not significant,  $\chi^2(8, 94) = .829, p > .05$ .

### **Technology and the Creation, Dissemination, or Receiving of Sexually Explicit Material**

When we asked if participants had ever taken a sexually explicit photo of themselves (i.e., "selfie"), most of the women reported "yes" (72.3%) compared to men (44.8%). Nearly half of the males reported "no" (55.2%) in comparison to females (27.7%). These frequencies were significant by gender,  $\chi^2(2, 94) = .026, p < .05$ .

When we asked if participants had ever taken a sexually explicit photo of themselves and given it to someone else (i.e., "sexting"), a larger number of females reported "yes"

(61.5%) when compared to males (41.4%). More males reported "no" (58.6%) compared to females who reported "no" (36.9%). The relationship for gender with these responses was not significant,  $\chi^2(4, 94) = .238, p > .05$ .

When we asked if participants had ever allowed someone to take a sexually explicit photo/video of them, the majority of females (75.4%) and males (69.0%) reported "no." Females (24.6%) and males (24.1%) reported "yes" at similar rates. The relationship for gender with these responses was not significant,  $\chi^2(4, 94) = .107, p > .05$ .

When we asked if participants have ever known anyone who has taken a sexually explicit photo (of themselves or had someone else take it), the majority of both females (86.2%) and males (82.8%) said "yes", while a few reported "no" (females, 10.8%; males, 3.4%). The relationship for gender with these responses was not significant,  $\chi^2(4, 94) = .279, p > .05$ .

When the participants were asked if they had ever known anyone who has shared sexually explicit photos of an individual without that person's consent (e.g., with friends, to brag), over half of both females (55.4%) and males (55.2%) said "yes." Concerning this question, about one-third of both the females and males reported "no" (females, 35.4%; males, 37.9%). The relationship for gender with these responses was not significant,  $\chi^2(4, 94) = .854, p > .05$ .

When we asked if participants have ever unintentionally received an explicit photo from someone else (without asking), nearly half of the females reported "yes" (47.7%) compared to males who reported "yes" (31.0%). More males (62.1%) than females (49.2%) reported "no." Again, the relationship for gender with these responses was not significant,  $\chi^2(4, 94) = .364, p > .05$ .

When asked if participants have known anyone who was the victim of revenge-porn (i.e., "cyber-sexual assault"), more males (27.6%) than females (24.6%) reported "yes." The relationship for gender with these responses was not significant,  $\chi^2(4, 94) = .441, p > .05$ . However, among this sample of college students, 3.1% reported they had been the victim of revenge-porn, and 100% of those were female.

## **Discussion**

### **Empirical and Theoretical Implications**

We surveyed college students at a midsize, public, southern university in the United States regarding behaviors surrounding the creation, dissemination, and receiving of sexually explicit images. Additionally, we explored the participants' responses concerning those individuals who become victimized with their private, sexually explicit images. Lastly, we explored the relationship with gender, and how the participants' responded. Specifically, the present investigation sought to address the gap of research surrounding rape culture and technology induced assault (e.g., CBSA).

We inquired about the participants technology use with their sexual exploration, and nearly half of the males, and nearly three-quarters of the females had taken a sexual image of themselves. Nearly half of the males, and over half of the females had shared a sexually explicit image with another individual through technology. At almost identical rates, both males and females had allowed someone else to take a sexually explicit video or image of themselves. Over 80% of both males and females knew someone who had also created sexually explicit material through technology. At nearly identical rates, over half of both males and females knew someone that shared a sexually explicit image with others, without the pictured individual's consent. Almost half of the females received an unsolicited sexually explicit image, while just over one-third of the males had received such an image without asking. About one-fourth of both males and females had known someone who was the victim of CBSA (e.g., "revenge-porn"). Among the sample, three percent had been the victim of CBSA themselves, and these were all women. These findings point to the fact that technology is most certainly being used as a form of sexual exploration among college students.

After looking into technology usage for sexual exploration among this sample of college psychology undergraduates, we explored responses specifically regarding victims of CBSA. Males strongly agreed with the statement, "if I took an intimate photo of my partner, I can do with it whatever I please," at 8 times the rate in which females did. Keep in mind that males and females both participated in the creation and sharing of sexually explicit images. This finding suggests that, even if unconsciously, these participants believe they can share a private, sexually explicit image anywhere they please, without the pictured individual's consent. This is suggestive of a double-standard, as well as the perpetuation of rape myth acceptance attitudes. Although previous research has pointed to females being pressured to take intimate photographs within their relationship (Bloom, 2016, National Campaign to Prevent Teen & Unplanned Pregnancy, 2008) more than males, our findings showed that both males and females agreed at nearly equal rates that it was normal to take sexually explicit photos within the parameters of a relationship. This finding suggests that, without pressure, the creation of sexual material may be a sexually healthy form of exploration in the new age of technology, as noted by some researchers (Henry & Powell, 2014a, 2015). However, upon exploring the relationship of gender with this question, we found gender was, in fact, a significant contributor to how participants responded. Thus, the reasoning behind why each gender creates sexual material may vary (e.g., feeling pressured, to feel feminine, to feel masculine), and future research would benefit from investigating this variation.

Due to the increased rate for which females are victimized online (Eaton et al., 2017; Henry & Powell, 2015; Franks,

2013), specifically when compared to males, we asked participants about the social consequences of women's naked photos ending up online. The majority of women agreed that women's social consequences are more severe than for males, while the majority of males disagreed with this statement. This discrepancy warrants further investigation. It is noteworthy that the relationship of gender with how participants responded was significant. Thus, it is possible that the findings pointed to a biased question on the instrument. However, the results may also point to the interplay of gender with the perpetuation of rape myth acceptance attitudes. For instance, sexual assault researchers (England & Bearak, 2014) highlighted that double standards among males still exist for sexual behavior and rape culture attitudes, indicating males are more likely to underestimate the consequences (e.g., social, emotional, physical, financial) of sexual assault, and show higher rates of victim blaming when compared to females. This may also be true for victims of CBSA, though more research is needed to explore these findings, and future research would benefit from asking about the social consequence of all genders.

Specifically, regarding victims of CBSA, nearly one out of four males and one of six females reported that the victims should not have created the sexual material in the first place. Essentially, even though sexually explicit photos are being taken, there appears to be a stigma towards those who have their materials without the consent shared online. Moreover, males agreed with the statement that if a woman's naked photo ends up online, she deserves what she gets for having taken the photos/videos at nearly twice the rate of females. Keep in mind, however, that nearly half of the men had taken a sexually explicit (i.e., selfie) photo of themselves and given it to someone else, and both males and females had allowed someone to take a sexually explicit (i.e., selfie) photo/video of them at almost equal rates. Thus, it appears that a double standard exists where males and females are taking sexually explicit photos but are more critical of others when the outcomes of those decisions results in cyber-sexual assault. Conversely, when participants responded to the statement that they could do whatever they please with a sexually explicit image, only five percent of females agreed with the statement, while a substantially larger portion of men, nearly thirty-five percent, agreed that they can do whatever they please with a sexually explicit image of another person. Moreover, the relationship of gender with how individuals responded to this question was significant, indicating that gender influences, at the very least, attitudes pertaining to the ethics of having sexually explicit images of another person. Due to the significance found for gender with this question, future research would benefit from exploring the perpetrators of CBSA, and specifically how gender influences the perpetuation of CBSA, as this is pivotal for the creation of prevention programs.

The above attitudes persisted, even though nearly one-third of both males and females had known someone who was the victim of revenge-porn (e.g., identification with the victim). In essence, some (not all) individuals are creating sexually intimate material, sharing it, receiving it, becoming victimized, or have even known a victim, but are also responding in a manner that places the blame of being victimized on the victim of CBSA (e.g., rape myth acceptance). This suggests to the researchers, also licensed mental health counselors, that efforts should be geared towards sexual education, technology and morality, and also on the prevention of CBSA. For instance, in the future we may benefit from teaching all genders about healthy sexual exploration with technology, as well as the unhealthy sharing of other's images, and finally how placing blame on CBSA victims perpetuates rape culture attitudes. In sum, let's teach the prevention of both CBSA in addition to the reduction of rape culture attitudes.

### Direction for Future Research

The goal of this study was to explore whether students utilize technology in the creation, dissemination, and receiving of sexually explicit material, if they had ever been the victim of revenge-porn, as well as potential stereotypes held pertaining to cyber-sexual assault.

We believe that rape culture attitudes influence the psychological consequences of CBSA; thus, if the creation of private photos does not inversely influence susceptibility to rape myth acceptance towards victims of CBSA, what does? Future research would benefit from exploring two specific areas regarding morality and sexting. First, research would benefit from focusing on prevention efforts of CBSA. Secondly, research would benefit from reducing the rape myth acceptance attitudes that give leverage to CBSA, making the crime much more psychologically damaging for victims. In essence, if we can't prevent private photos from being shared without one's consent, how can we shift the culture norm so that victims are not further taunted and scrutinized by their peers, colleagues, and society? This may be the key in reducing some of the detrimental mental health outcomes for CBSA victims, though future research is needed to support this claim

### Limitations

It is important to note that while this topic has only recently gained attention of mental health professionals, this study has its limitations. First, a small sample from a single undergraduate psychology course at a conservative southern university certainly limits generalizability and cross-cultural comparisons. This convenience sample also limits the conclusions of the research; in the future researchers may want to utilize random sampling on a college campus to help with generalizability as well as replication (Cohen, 1992). Please

also note the lack of diversity within the sample. The majority of the sample identified as white, heterosexual females and males. The results of this study may have been different had the sample been more culturally diverse.

Regarding instrumentation, while the survey was created and reviewed by a panel of mental health experts, it was also not validated. Thus, content validity, or the ability to know we are measuring a specific construct of interest may be lacking (Cronbach & Meehl, 1955). It is important to utilize validated instruments in research design, though new areas of study often lack these (Marganski & Fauth, 2013). This measurement was used due to inadequate existing measurements. With this in mind, future researchers would benefit from validating this instrument, or something similar, and also offering it alongside another rape myth attitudes questionnaire to learn if the results are comparable. Also, while explicit definitions of both revenge porn and sexually explicit were offered at the beginning of this survey to increase reliability, a thorough definition of sexting was not offered, which could have resulted in an underreporting of sexting among this sample. This study does serve to initiate the conversation surrounding how college students are exploring their sexuality, as well as the continuation of rape culture attitudes on college campuses, specifically in regard to online cyber-sexual assault.

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# Clinical Implications in Vaginal Orgasm Response

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Previous research has shown that counselors feel uncomfortable addressing clients' sexual concerns due to a lack of education on topics related to human sexuality. Various studies have attempted to identify the characteristics of vaginal orgasm, including whether women and other people with vaginas (PWV) can achieve different kinds of orgasms. The current study examines responses to participants surveyed across the United States on their orgasm response and compares responses of participants who achieved orgasm through masturbation and those who achieved orgasm through sex with a partner to determine whether PWV experience one kind of orgasm during masturbation and experience a different kind of orgasm during sex with a partner. Results from the current study suggest that there are two distinct orgasm experiences achieved by PWV which differ in physiological and psychological response. Counselors and counselor educators can use results from this study to help expand their knowledge on sexual response to feel more confident in their practice.

*Keywords:* vaginal orgasm, masturbation, partnered sex, people with vaginas

## Introduction

Human sexuality is a significant aspect of human development and experience (Jahoda & Pownall, 2013). Because of this, it is plausible to believe that mental health counselors may encounter a client seeking treatment for a sexual issue. A woman who may not be formally educated on topics related to her sexuality could face embarrassment when asked by a counselor if she has ever achieved sensations associated with orgasm in the past. Previous literature has shown that mental health clinicians from various disciplines, including counselors, do not always feel comfortable assessing sexuality-related topics with clients (James, 2007; Kazukauskas & Lam, 2009; Bloom, Gutierrez, & Lambie, 2015; Lenes, Swank, & Nash, 2015). Counselors have reported that they do not feel like they have received adequate training on topics related to human sexuality to feel confident enough in addressing these concerns with their clients (Bloom et al., 2015). As of 2016, only the state of Florida requires coursework in human sexuality in order to obtain independent licensure as a professional counselor (American Counseling Association, 2016).

There are several reasons why individuals may seek counseling for sexuality-related issues. Sexual dysfunction, such as dyspareunia or anorgasmia, related to depression could be one of those factors. Increased depression has been shown to

correlate with increased sexual dysfunction (Fabre & Smith, 2013). Previous literature has identified the effects of depression and selective serotonin reuptake inhibitors (SSRIs) on sexual function as well (Fabre & Smith, 2013). Researchers have even suggested that sexual dysfunction is just as important as other diagnostic criteria for depression, and that sexual dysfunction should be measured in depressed individuals before beginning medication treatment for depression (Fabre & Smith, 2013).

Though many agree that sexuality education should receive more recognition, there is a considerable amount of vagueness regarding human sexuality for counselors-in-training and licensure as a licensed professional counselor (LPC, Diambra, Pollard, Gamble, & Banks, 2016). Dup-

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koski's (2012) analysis of the American Counseling Association (ACA) and Association for Counselor Education (ACES) Syllabus Clearinghouse revealed that only 57 out of 395 syllabi included the word 'sex,' and only four courses had sexuality as their focus. The National Board for Certified Counselors (NBCC) has not required a course in human sexuality for National Certified Counselor certification in the past (NBCC, 2012). However, counselor educators have advocated for more specific information related to human sexuality to be introduced into counselor education programs, integrating ideas from the American Association of Sexuality Educators, Counselors, and Therapists (AASECT; Zeglin, Dam, & Hergenrather, 2017). Zeglin et al. (2017) proposed ten competency domains to aid counselors in working more effectively with clients: Ethical/Professional Behavior, History and Systems, Anatomy/Physiology, Sexual Identity, Sexual Development, Intimacy and Interpersonal Relationships, Pleasure and Sexual Lifestyles, Sexual Functioning, Health/Medical Factors, and Sexual Exploitation.

Orgasm response is one concern for which a person might seek counseling. Kinsey, Pomeroy, Martin, and Gebhard (1953) attempted to define orgasm in broad terms, defining it as a sudden reduction of sexual tension. During orgasm, there is a peak in heart rate, blood pressure, and in respiration (Masters & Johnson, 1966). Often during orgasm, the extreme pleasure causes a characteristic 'orgasm face' as well (Masters & Johnson, 1966; Levin, 2014). Most studies have focused on the genital physiologic changes that occur during orgasm, mainly studying the muscle contractions that occur (Mah & Binik, 2001; Dubray, Gérard, Beaulieu-Prévost, & Courtois, 2017). Researchers have tried to broaden the definition of orgasm by including the psychological effects that are associated with orgasm (Mah & Binik, 2001; Dubray et al., 2017).

Previous literature suggested that all vaginal orgasms are basically the same (King, Belsky, Mah, & Binik, 2010). However, the idea that there are variations between vaginal orgasms and clitoral orgasms has been under-researched, but has been a popular opinion (Wimpissinger, Springer, & Stackl, 2013). King and Belsky (2012) reported this as the 'Masters and Johnson model' of female orgasm: one type of orgasm, no matter how it is brought on or by whom. Contrary to this, previous research has shown that women report that their orgasms differ in intensity, location, and phenomenology, as well as emotional components (Hite, 1976). Several previous researchers have reported that especially in the female, stimulation of different sites creates different orgasmic feelings (Levin, 2004). This has been found to be especially true with the clitoris (described as sharp, intense, 'electrical' feelings) in comparison to the anterior wall of the vagina (described as throbbing, deep feelings; Levin, 2004).

King and Belsky (2012) reported that women frequently reported experiencing more than one kind of orgasm. Partic-

ipants in their study reported two different kinds of orgasm. One orgasm was experienced "deep inside," and the other was experienced "on the surface" (p. 1154). Characteristics of deeper orgasms were experiences such as shuddering of the entire body and feelings of intense pleasure, loss of self, and loss of thought. King and Belsky (2012) reported that deeper orgasms were significantly more likely to occur through sex where there was penetration involving a partner.

The current study is similar to the study conducted by King, Belsky, Mah, and Binik (2010), where it was concluded that women can achieve up to four differing types of orgasm. Unlike the 2011 study, however, this study helps to provide insight on the physiological sensations achieved during orgasm by utilizing the Bodily Sensations of Orgasm (BSO) questionnaire first published in 2017 (Dubray et al., 2017).

We hypothesize that participants will report experiencing more than one kind orgasm as previous literature has shown. We hypothesize that these different experiences will be identified in participants who report experiencing orgasm through masturbation versus participants who report experiencing orgasm through sex with a partner. Participants were divided into these groups based upon previous studies examining biopsychosocial models of orgasm experience that speculate orgasm is comprised of both physical and psychological/interpersonal experiences (Davidson, 1980; Warner, 1981; Newcomb & Bentler, 1983; Mah & Binik, 2002). This was also the design of King et al.'s (2010) study, as well as Dubray et al.'s (2017) study confirming the validity of the BSO questionnaire. The current study will help determine whether women and other people with vaginas (PWV) report experiencing different vaginal orgasm experiences during masturbation and sex with a partner. We hypothesize that these orgasm experiences will vary between both physiological and psychological responses.

## Methods

### Participants

The participants for this study included 369 cisgender women and gender non-conforming individuals with vaginas. For the purpose of this study, cisgender women were participants whose gender identity matches the sex they were assigned at birth, and gender non-conforming individuals with vaginas were participants who do not identify as a gender other than their biological sex and were born with a vulva and vagina. This study was a doctoral dissertation that obtained Institutional Review Board approval through University of the Cumberland. Individuals were recruited to participate by social media or email invitation. All information gathered for this study was anonymous and completely voluntary. Participants confirmed that they had either experienced orgasm through solitary masturbation (n = 204) or

during sex with a partner (n = 165).

Participants' age ranges varied greatly between 18 and 65 and over, with the most reported age range being 25-34 (n = 193). Education levels varied greatly between participants as well, with the most reported education level being 'graduate degree' (n = 179). A significant number of participants identified as 'white' (n = 313), cisgender (n = 353), heterosexual (n = 269), Christian (n = 152), married (n = 162), and 'very satisfied' in their relationship (n = 168). Participants' location throughout the United States varied greatly, the most reported region of the United States being 'East South Central,' which included Alabama, Kentucky, Mississippi, and Tennessee (n = 102).

## Materials

**Bodily Sensations of Orgasm questionnaire.** The Bodily Sensations of Orgasm questionnaire (BSO) is a 22-item self-report questionnaire describing various sensations and reactions associated with achieving orgasm (Dubray et al., 2017). Utilizing previous literature and research, a list of sensations was compiled of 45 items initially. These items were sorted into four categories according to physiological response and Courtois et al.'s (2014) neurophysiological model of orgasm: cardiovascular sensations, autonomic sensations, muscular sensations, and negative sensations such as headaches (Dubray et al., 2017). Participants were asked to rate each item based on the extent to which they experienced each sensation using a 5-point Likert scale where '1' means "not at all" and '5' means "extremely". After testing for construct validity, wording for some items was changed, and the number of items was reduced to 28 (Dubray et al., 2017)(Dubray et al., 2017).

**Orgasm Rating Scale.** The Orgasm Rating Scale (ORS) is a 40-item self-report adjective rating scale. The ORS consists of two subscales measuring sensory and cognitive-affective dimensions of orgasm, based upon a two-dimensional model of the psychological experience of orgasm that has been previously investigated (Mah & Binik, 2001). The sensory dimension of the scale represents the perception of physiological events that occur (e.g., pelvic contractions), where the cognitive-affective dimension of the scale represents the subjective evaluations (e.g. intensity) and emotions (e.g. love, intimacy) that are associated with orgasm (Fisher, Davis, & Yarber, 2010). Participants were asked to rate each adjective on a 0-5 Likert scale according to how well each adjective describes their most recent orgasm experience where '1' means "not at all" and '5' means "extremely" (Fisher et al., 2010). The ORS was developed to describe orgasms experienced by both masturbation and sex with a partner.

## Procedure

As previously mentioned, participants were recruited through social media platforms and email invitations. Participants who chose to participate were asked to follow the link to SurveyMonkey.com to complete the materials. Participants were prompted to read the informed consent, agree that they were born with a vagina, confirm that they had achieved orgasm through solitary masturbation and sex with a partner in their lifetime, and agree that they were 18 years of age or older. Participants were then asked to complete the BSO questionnaire on a 5-point Likert scale, followed by the ORS on a 5-point Likert scale. Lastly, participants were asked demographic questions about themselves and debriefed regarding the nature of the study.

## Results

A one-way analysis of variance (ANOVA) was conducted to compare the means between the 'solitary masturbation' and 'sex with a partner' sample groups. Data analysis showed statistical significance for some of the variables. For physiological sensations, there was a significant difference found for 'perspiration' between the solitary masturbation and sex with a partner group,  $F(6, 362) = 3.465, p = .002, \eta^2 = 0.05$ . There was a statistical significance found for 'choppy/shallow breathing (apnea)' between the two groups,  $F(6, 362) = 3.436, p = .003, \eta^2 = 0.05$ . There was a statistical significance found for 'shivers/goosebumps' between groups,  $F(6, 362) = 2.842, p = .011, \eta^2 = 0.04$ . There was a statistical significance found for 'hypersensitive clitoris' found between the two independent groups,  $F(6, 362) = 3.210, p = .004, \eta^2 = 0.05$ . There was significant difference found between groups for 'flowing,'  $F(6, 362) = 2.137, p = .049, \eta^2 = 0.03$ . There was also a significant difference found between the two independent groups for 'vulvular pulsations,'  $F(6, 362) = 2.405, p = .048, \eta^2 = 0.03$ . For psychological sensations, there was a significant difference found for 'trembling' between independent groups,  $F(6, 362) = 2.647, p = .016, \eta^2 = 0.04$ . as well as 'spurting,'  $F(6, 362), p = .005, \eta^2 = 0.05$ . Tables 1 and 2 display the results of the analysis along with group means and SD.

## Discussion

As discussed previously, scholars have attempted to research the possibility that women have more than one kind of orgasm. However, the question has never been definitively answered. While Masters and Johnson (1966) concluded that women could only achieve one type of orgasm, more current scholars have proposed the possibility of as many as four different types of orgasms women can achieve (King et al., 2010). The analysis for this study showed a significant difference between the orgasms reported during partnered sex and orgasms reported during solo sex (i.e., masturbation) on the

Table 1  
Group Means and Standard Deviations for Bodily Sensations of Orgasm Questionnaire

Scale	<i>M</i>	<i>SD</i>
Increased heartbeat	3.38/3.61	0.93/0.90
Heart beating stronger	3.30/3.52	1.01/0.94
Faster breathing	3.33/3.88	0.98/0.88
Overall muscular tension	3.94/4.04	0.91/0.87
Choppy/shallow breathing	2.65/2.96	1.28/1.26
Increased blood pressure	2.62/2.68	1.09/1.02
Moaning	2.53/3.7	1.23/1.08
Hardening nipples	3.02/3.35	1.23/1.17
Vulvular pulsations	3.89/4.01	1.09/1.04
Shivers/Goosebumps	2.53/2.69	1.37/1.33
Anal contraction	1.94/1.97	1.06/1.07
Hypersensitive clitoris	4.04/4.09	1.09/1.10
Clitoral pulsation	3.68/3.56	1.21/1.26
Lower limbs spasm	2.71/2.48	1.36/1.30
Abdominal contractions	2.69/2.48	1.26/1.24
Cranial pulsations/Headaches	1.35/1.43	0.81/0.92
Facial tingling	1.25/1.37	0.65/0.85
Reddening of the skin/Rash	1.57/1.64	1.03/0.99
Perspiration	1.95/2.44	0.97/1.02
Hot flashes	1.58/1.67	0.90/1.01

Note. Values are written 'masturbation group scores/sex with partner group scores.'

following variables: perspiration, choppy/shallow breathing (apnea), shivers/goosebumps, hypersensitive clitoris, vulvular pulsations, flowing, trembling, and spurting.

Based upon the analysis, there is some evidence to argue that PWV have at least two different experiences of orgasm: one experienced by solitary masturbation and a different one experienced by sex with a partner. This is consistent with Mah and Binik's (2002) results, as well as King et al.'s (2010) results. The use of the BSO questionnaire helped to provide further distinction in the different kinds of orgasms, which has yet to be done in a study of this type or this magnitude in the United States. This data is also consistent with King and Belsky's (2012) previous results, where women reported experiencing two different kinds of orgasms.

There are several limitations of this study that should be acknowledged. The first limitation is the lack of laboratory evidence in the current study. In previous studies of this kind, several of the participants have volunteered to undergo clinical tests such as fMRIs and observation by the researchers or laboratory assistants. However, this study was conducted via anonymous self-report, with little ability to control for variables that could be observed in a lab setting. A study like this would allow medical and mental health professionals to examine any differences in variables such as brain function in women during solitary masturbation and sex with a partner. An additional benefit of laboratory research would be

Table 2  
Group Means and Standard Deviations for Orgasm Rating Scale

Scale	<i>M</i>	<i>SD</i>
Building	3.17/3.49	1.30/1.29
Swelling	2.30/2.33	1.18/1.28
Flowing	2.12/2.48	1.23/1.32
Close	1.92/3.27	1.20/1.42
Pleasurable	4.37/4.56	0.79/0.70
Soothing	3.06/2.84	1.29/1.39
Quivering	2.84/3.01	1.24/1.29
Passionate	2.45/3.99	1.36/1.00
Relaxing	3.57/3.33	1.21/1.29
Flooding	2.23/2.54	1.36/1.39
Elated	2.93/3.52	1.23/1.32
Throbbing	3.18/3.22	1.27/1.30
Rapturous	2.11/2.47	1.29/1.42
Spreading	2.24/2.24	1.33/1.30
Flushing	2.25/2.48	1.25/1.25
Fulfilling	3.71/4.25	1.14/0.92
Shooting	1.68/1.88	1.10/1.28
Euphoric	3.17/3.75	1.29/1.15
Unifying	1.94/3.41	1.25/1.35
Peaceful	2.62/2.73	1.29/1.26
Tender	2.14/2.84	1.24/1.25
Shuddering	2.67/2.73	1.31/1.34
Loving	2.17/3.93	1.26/1.09
Trembling	2.67/2.95	1.25/1.26
Satisfying	4.05/4.46	0.91/0.73
Ecstatic	2.78/3.42	1.34/1.27
Spurting	1.58/1.75	1.02/1.14
Pulsating	3.36/3.42	1.22/1.22

Note. Values are written 'masturbation group scores/sex with partner group scores.'

monitoring participants' completion of the BSO within thirty minutes of experiencing orgasm. Self-report data collection, used in this study, does not allow for the researcher to know if that took place, while data collection in other settings, such as a sexuality research laboratory, could do so.

A recommendation for future research would be conducting qualitative interviews with participants. This would allow participants to define their own orgasm experience, as well as allow participants to define what terms like 'woman' and 'gender non-conforming individual' mean to them. Furthermore, future research could examine the variations in response of the ORS and BSO between participants who identify as being born with a vulva and vagina, and participants who have undergone gender confirmation surgery to have a vulva and vagina. Researchers could also examine responses of individuals who self-identify as 'intersex,' meaning they have both male and female sex organs. Another recommendation would be more widespread participant data collection

in both the United States and other countries. Future research could expand to allow for comparison between participants from all locations. This could allow for a cross-cultural comparison of vaginal orgasm response, as well as cross-cultural definitions of terms like ‘woman’ and ‘gender non-conforming individual.’

One recommendation for future practice is for counselor educators to use the results of this study in their classrooms. Specifically, counselor educators teaching courses on human sexuality can use the results of this study to help educate counseling students on the experience of the vaginal orgasm, as well as on how vaginal orgasms differ from one another, and how vaginal orgasms differ from penile orgasms. A recommendation for clinicians is to utilize data from this study to further expand their own knowledge on the subject of orgasm. Clinicians who feel that they are lacking in knowledge and comfortability in regard to vaginal orgasm can use this information as a learning tool to feel more confident in addressing clients’ concerns related to vaginal orgasm response.

Another recommendation for future practice is for counselor education programs to expand their curriculums to include human sexuality courses. Previous research has shown that clinicians struggle to discuss human sexuality with their clients for various reasons (Kazukauskas & Lam, 2009). There is a lack of education on the topic of human sexuality within several counselor education programs (Dupkoski, 2012). Scholars have suggested that education on clinical sexuality and a clinician’s comfort with the topic of human sexuality allow for clinicians to discuss these topics with their clients (Juergens, Smedema, & Berven, 2009). Currently, Florida is the only state that requires individuals seeking licensure as a professional counselor to have completed coursework in human sexuality (ACA, 2016). While completing a course in human sexuality is not a requirement for licensure as a Licensed Professional Counselor in all states, allowing for students to take a course on human sexuality will help counselors in training to feel more comfortable and knowledgeable about these topics in their clinical practice.

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# Sexual Wellness and Rare Disease Considerations: A Behavioral Case Conceptualization and Approach to Counseling Treatment

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Sexual wellness is infrequently addressed with individuals with a rare disease. Counselors must be competent in working with sexual wellness issues, especially those related to medical conditions, since clients may not share those concerns with healthcare providers. This article presents a case scenario involving a client living with a rare disease called Hereditary Angioedema, the symptoms of which present challenges to her intimate and sexual relationship with her partner due to unpredictable and painful swelling. A behavioral theoretical lens is used to conceptualize the case scenario and inform treatment. Implications for counselor competency, interdisciplinary collaboration, and client empowerment toward advocacy are discussed.

*Keywords:* rare disease, swelling, sensate focus, systematic desensitization, counselor competency

## Introduction

Approximately one in ten people in the United States has a rare disease, with over 7,000 uniquely identified rare diseases (Genes, 2019). Healthcare providers often lack knowledge of rare diseases, thereby increasing an individual's frustration with healthcare experiences. With increasing frustration in general, individuals may not disclose to their healthcare providers secondary issues stemming from their rare disease, such as their sexual wellness. Even in cases where individuals do disclose secondary issues, those pertaining to their sexuality are not frequently discussed (Anllo, 2016; Catamero et al., 2017) or inquired about by healthcare providers (Jensen, Broesby-Olsen, Bindlev-Jensen, & Nielsen, 2018). Krebs (2007) comprehensively documents how patients do not voluntarily discuss sexual concerns with their healthcare providers.

When individuals feel that secondary issues stemming from their rare disease are not being heard or taken seriously by their healthcare providers, counselors and other mental health professionals may instead become tasked with addressing such secondary issues in counseling. Even when healthcare providers do approach the individual's rare disease seriously, many physicians report needing additional assistance from non-physicians (e.g., counselors) to fully manage all aspects of the disease (SHIRE, 2013). Kravitz et al. (2006) found some support for physicians making mental health referrals, but physicians' offices were not found to be likely to offer significant assistance in helping individuals follow-through on mental health referrals. Hammer,

Spiker, and Perrin (2018) discussed how most patients will initially seek mental health assistance through their primary care provider, but only about one third will follow through on a referral to a mental health provider.

Clients experiencing concerns related to sexual wellness as a secondary issue of their rare disease may initially present in counseling with a relationship issue. Krebs (2007) discussed ways that relational factors may influence sexual functioning in individuals diagnosed with a medical illness. Identifying and addressing the secondary issue in counseling may be crucial for the client to resolve the initial presenting concern and have a positive perception of the counseling treatment.

Notably, the therapeutic alliance and relationship factors are strongly associated with therapeutic treatment outcomes (Horvath, Re, Flückiger, & Symonds, 2011; Suzuki & Farber, 2016). When a client initially seeks assistance for an issue, it may take time to develop a trusting therapeutic relationship. Once the client senses that the counselor is an em-

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pathic person, this client perception plays a part in shaping the strength of the therapeutic relationship (Horvath, 2015). Once the client has this trusting perception of the counselor, then a client may be more likely to share sexual issues in sessions. Understandably, the more clients perceive counselors as being empathic and open to discussing sexual stressors, the more likely they become to disclose ways in which their presenting concerns are influenced by any sexual concerns.

Even when clients perceive that counselors might be receptive to discussing relevant sexual issues, counselors and other types of mental health providers often do not directly ask clients about their sexual concerns (Hipp & Carlson, 2019; Miller & Byers, 2009). Levine, Risen, and Althof (2016) identified numerous primary concerns counselors may have in addressing client sexual issues: (a) being unaccustomed to talking about sex, (b) not knowing what sexual information is necessary to ask about, (c) not understanding something the client shares, (d) being uncertain how to respond to clients disclosing sexual concerns, and (e) embarrassing the client. These concerns may lead the counselor to avoid discussing topics related to client sexuality. Unfortunately, clients often do not discuss sexual issues unless the counselor asks in a way that demonstrates openness and comfort in discussing the topic (Miller & Byers, 2011).

In addition to potentially lacking knowledge about addressing sexual issues in counseling, counselors may also lack knowledge about rare diseases since that is not a counselor's specialty area. Even healthcare professionals with a medical background may lack knowledge regarding rare diseases. For example, Shire (2013) found that 67% of patients with rare diseases frequently had to provide education on their rare disease to their healthcare provider. There is no one specialty which oversees all rare diseases. Each rare disease presents unique concerns and challenges for which there may not be extensive research to inform treatment. As an example, 93-95% of rare diseases have no FDA approved treatment (Orphanet, 2018). With over 7,000 identified rare diseases, it would be outside the typical scope of competence for counselors to have more knowledge on rare diseases than healthcare professionals.

In addition, training in topics related to sexuality and sexual wellness are not competency areas covered by the Council for Accreditation of Counseling and Related Education Programs' (CACREP; 2016) core curricular standards. Unless a counselor attended a CACREP-accredited marriage, couple, and family counseling program, in which Standard 5.F.2.e – human sexuality and its effect on couple and family functioning – is required within the specialty area's contextual dimension curricular standards, it is possible for counselors to have no formal education in addressing client sexuality or sexual wellness issues. Furthermore, even if counselors have had formal training as a part of their educational background, they may still experience discomfort or hesi-

tancy in discussing sexual issues with individual clients or couples (Hipp & Carlson, 2019; Levine et al., 2016).

A case scenario for a client with a type of rare disease called Hereditary Angioedema (HAE) is presented below to illustrate how secondary issues pertaining to sexuality and sexual wellness may initially present to counseling as a relationship issue involving concerns with one's partner. HAE incidence estimates range between 1 in 30,000 and 1 in 50,000 (Maurer et al., 2018). HAE's common symptoms include facial, tongue, airway, abdominal, extremities, and genital swelling (Maurer et al., 2018). These swells can be extremely painful, with abdominal swells frequently causing extreme diarrhea and vomiting. A swell that begins in one location can also travel to another location. Thus, a swell that begins in the hands could travel to the abdominal area and then subsequently to the face and airway. The pathophysiology of how or why the swells travel remains unknown. These swells can be spontaneous without a precipitating factor, or they can be triggered by seemingly innocuous activities with repetitive motion such as painting, hammering, or mowing the lawn. Thus, seemingly innocuous sexual encounters can lead to genital swelling in patients with HAE.

The client in the below case scenario represents an amalgamation of multiple individual experiences vocalized through HAE-specific support groups, rather than the experience of any singular individual with HAE. A theme discussed in these support groups, but not known to be present in the literature, is the overall impact of HAE on sexual experiences and the subsequent impact on the quality of life for these individuals and their partners. Although sexual activity is known to be a possible trigger for a severe swell (Banerji & Riedl, 2016), no known literature addresses counseling interventions for individuals with HAE experiencing fear surrounding sexual activities with a partner due to the possibility of a swell. This paper applies empirically-supported behavioral counseling approaches to the case scenario below to address the client's experienced fear.

### Case Scenario

A 33-year-old heterosexual female client, "Jane," initially presents to individual counseling with concerns about her relationship with her significant other "Paul." Jane states that she and Paul have grown apart, do not speak as often as they used to, and she is afraid that he will leave her. Upon further exploration, Jane reveals she frequently experiences fatigue related to a rare disease called Hereditary Angioedema (HAE). Jane explains that HAE causes her to have intermittent, unpredictable severe swelling that requires quick medical intervention to prevent swelling from closing her airways. Jane has most commonly experienced swelling in facial mucosal tissues (e.g., mouth, tongue, and lips), but she has also experienced swelling in her hands, stomach, legs, and genitals. Jane confirms that she is under a physician's

care for HAE, but she has not disclosed the locations of all her swelling, such as the genital swelling, to her healthcare team.

Upon hearing that the swelling has the potential to affect her genital region, the counselor asks Jane about how HAE has affected her sexual relationship with herself and with Paul. Initially appearing surprised that the counselor asked about her sexuality, Jane cautiously states that overall, HAE has not affected her desire for sexual activities with herself or Paul. She reports engaging in self-stimulation when desired without any complications. Jane emphasizes that her primary sexual concern relates to increasingly denying Paul's sexual advances.

The counselor asks Jane to share more about what leads her to deny Paul's sexual advances since she states having sexual desire for intimacy with Paul and is concerned about him leaving her. Jane shares that in addition to the fatigue she experiences from HAE, she also experiences apprehension and anxiety due to some past sexual encounters. The counselor remains open to learning more and asks Jane what has happened in the past that contributes to her present apprehension toward sexual activity with Paul.

Jane shares that three months ago, after providing oral sex to Paul, she suffered from mouth and lip swelling. Paul then commenced intercourse as they had done in the past, not realizing the client's mouth and lips were swelling. Jane did not mention it at the time because she felt guilty asking Paul to stop because she wanted him to be satisfied. Jane admits that she also wanted to be satisfied through intercourse, which was another reason she did not ask him to stop. Jane states her swelling can be inconsistent in severity, and she had hoped the swelling would not become worse. Jane shares that additional swelling developed in her genital area during intercourse, and after intercourse basic functions such as sitting in a chair or even elimination were painful because of the swelling brought on by intercourse. Jane thinks that she may not have been as lubricated during intercourse as she has been at other times without swelling problems, and the resulting abrasive friction may have contributed to the genital swelling. Jane did not tell Paul about the pain she experienced afterward because she did not want him to feel to blame for her being in pain. She also did not tell her healthcare providers about what happened because she is not comfortable talking to them about how sex has occasionally caused swells. Additionally, her healthcare providers have never asked her about how her sexuality has been affected by HAE symptoms, so she is uncertain how they would respond if she were to mention it.

Jane reports often feeling shame and guilt for increasingly denying Paul's advances for sexual intimacy due to fatigue and fear of sexual activities resulting in swelling even though swelling has not been a consistent problem for her every time she engages in sexual activity. Jane is concerned that if she is

unable to get past her fear of engaging in sexual or intimate activities with Paul that he will end their relationship or engage in an affair to meet his basic sexual or intimacy needs. Jane claims that she has always considered herself to be a sexual person, desiring to pleasure and be pleased within a relationship. She feels she is having trouble comfortably re-engaging with Paul in a sexual way after the painful incident involving genital swelling. She sees this as what is underlying her current relationship issues with Paul. Jane asks her counselor how counseling might be able to help her get past her feelings of fear and guilt related to engaging in sexual activity with Paul.

### Special Considerations

First and foremost, a counselor working with a client affected by a rare disease would want to develop therapeutic rapport and trust to strengthen the therapeutic relationship (Horvath, 2015). Throughout Jane's case, the counselor remains open and nonjudgmental while learning about Jane's experiences within her relationship with Paul. While developing trust and rapport with Jane, the counselor would also want to validate and normalize Jane's experiences by sharing how living with medical illness is known to have the potential to affect one's relationship and sexual functioning (Krebs, 2007).

Once Jane perceives the counselor as empathic and willing to collaborate with her to address her concerns, the counselor would want to obtain a release of information to speak directly with the client's healthcare team to coordinate care. The counselor would want to learn more about the specific medical condition and any activities that would be medically ill-advised, both from the client's healthcare team as well as from organizations specializing in rare diseases, such as the National Organization for Rare Disorders (NORD) and Global Genes. In situations like Jane's, where the client may be uncomfortable mentioning sexual activities to healthcare providers, counselors may assist in advocating for the importance of sexual wellness by directly asking about it when speaking with the healthcare team. Directly inquiring about any ill-advised sexual behaviors not only normalizes sexuality as a basic human need for many individuals (Maslow, 1943), but it also might encourage the healthcare team to follow up with clients like Jane about any experienced problems with sexual activity. Considering sexual activity may be perceived as a basic physiologic function for many individuals, as long as the healthcare team does not identify all sexual activities as medically ill-advised, counselors can deem relevant perceived client needs related to sexuality just as important as any other identified biopsychosocial need (Engel, 1977).

Specific to the rare disease HAE in Jane's case scenario, medical treatments continue to become available that can help manage symptoms of the disease. However, new medi-

cal innovations to manage disease symptoms do not eradicate fear experienced due to events prior to the release of newer medications. When working with clients affected by HAE and other rare diseases, counselors should explore what medications clients were taking when they experienced adverse events related to their presenting concerns. Newer medications that can manage symptoms more effectively may not have been available or affordable when the client experienced past significant physical symptoms. Counselors should ensure they discuss medication history with a client's healthcare team as a part of care coordination.

For Jane's case scenario, some points are especially important to emphasize. Swelling influenced by HAE is not a consistent medical issue. Although swelling may have occurred previously from a specific trigger, this does not guarantee swelling will occur again at the same severity the next time the trigger is experienced. Swelling is more likely to occur when individuals have been experiencing heightened levels of stress or recent swelling in other body locations (Zuraw, 2008). Discussions within HAE support communities related to swelling from sexual activity have identified contact with abrasive surfaces (e.g., fingernails, callouses, or uneven edges on toys) as especially likely to lead to problematic swelling. Issues from abrasive surfaces tend to be more problematic in sexual activities with another individual if the individual is unaware of the abrasive surface or why it may be problematic.

Minimal discussion within HAE support communities mentions self-stimulation. Since individuals tend to have enough self-awareness to stop self-stimulation if they start to feel initial signs of a swell, this may help explain why self-stimulation is relatively unheard of as a common trigger for HAE swelling. Alternatively, individuals with HAE who are aware of the swelling risks posed by abrasive surfaces may take more precautions in avoiding any abrasive surfaces when engaging in self-stimulation. Notably, stimulation of mucosal tissue itself does not guarantee swelling. Swelling tends to be due to more complex factors that can make a swell's severity difficult to predict.

Finally, the treatment strategies identified in the treatment plan below are merely suggestions that may be discussed collaboratively with clients. All identified treatment strategies are supported in clinical practice for a variety of presenting client concerns. Currently, there is no known literature addressing how to work with clients experiencing fear of engaging in sexual activities due to previous adverse reactions from a rare disease. When many healthcare providers offer minimal information to help address sexual wellness needs of individuals with rare diseases, counselors can collaboratively offer suggestions from clinical practice to the client that are not contraindicated by the client's healthcare team.

### Case Scenario Conceptualization

Prior to developing a treatment plan for Jane, her counselor would want to develop a case conceptualization that is theoretically grounded. When counselors theoretically conceptualize client situations, they gain a clearer tentative idea about what has contributed to the client's presenting situation through their chosen theoretical lens. From this theoretically-informed understanding of the client, the counselor can then select possible treatment approaches aligned with the chosen theoretical lens. When the conceptualization process is overlooked in favor of going directly to treatment planning, "there may be treatment chaos" (Berman, 2015, p. 1) due to limited intentional client understanding guided by theory. Jane's case will be explored through a behavioral therapeutic lens prior to discussing possible treatment approaches.

The case scenario demonstrates that if the counselor had not further inquired about Jane denying Paul's sexual advances, the counselor would have missed important information. The couple's intimate relationship and Jane's concerns about her partner's satisfaction within the relationship are influenced by prior experiences of unpredictable adverse physical effects during sexual activity as influenced by her rare disease. The counselor would have also missed how prior adverse physical sensations after sexual activity continue to affect Jane's engagement in intimate and sexual activities with her partner.

In behaviorism, the primary focus of counseling is on behaviors (Berman, 2015). Even more specifically, a counselor approaching this case scenario from a behavioral lens would want to conduct a functional analysis of the antecedents (i.e., what occurs before the indicated behavior) and the consequences (i.e., what occurs after the indicated behavior) to better understand what has led to the development of the indicated behavior and what serves to continue the indicated behavior. In this case scenario, Jane appears to be presenting primarily with concerns about reduced behavioral engagement in sexual activity with Paul.

In exploring what has led to Jane denying Paul's advances, the counselor begins to see how the behavior of denying advances has become classically conditioned, partly due to physical symptoms resulting from her rare disease. Jane's initial physical reason for denying Paul's sexual advances – fatigue – is a common reason stated by individuals for denying sexual advances, which may have no etiology from a rare disease or any other sort of medical condition but rather general life stressors (Basson, 2001). Jane's perceived fatigue may serve as an unconditioned stimulus, leading to the unconditioned response of denying sexual advances. However, as the counselor learns by further inquiring about Jane's feelings of denying advances, her existing fatigue, her prior physical experiences of swelling mucosal tissues, and subsequent fear of the outcome from engaging in sexual activities

are potential activators of the sympathetic nervous system. A fear response as described above can activate the sympathetic nervous system, resulting in a potential reduction in natural lubrication and unintentional vaginal muscle constriction (Fleischman, Hamilton, Fessler, & Meston, 2015), and may serve as conditioned stimuli leading to the now conditioned response of denying sexual advances. Furthermore, this conditioned fear of outcomes from sexual activity may have generalized to other intimate behaviors involving mucosal tissues, such as kissing, which may result in Jane being apprehensive of any physical intimate behavior with Paul. This generalization of fear related to intimate behaviors can help explain her concerns about Paul not having his basic intimacy needs met and what choices he might make in meeting those needs.

In exploring what has led to Jane's continuation of denying Paul's advances, the counselor begins to see how that behavior has become operantly conditioned, partly due to physical symptoms resulting from her rare disease. Jane stated that during a previous sexual experience with Paul in which her genitalia swelled (unrelated to any other physical cause – such as vaginismus – but rather as a symptom of the rare disease), she did not mention it to Paul due to already feeling shame and guilt from past instances of denial. Jane experienced significant pain afterward in basic functions involving the general genital area. This pain experienced afterward has positively punished her engagement in sexual activities, meaning her engagement in sexual activities has declined as a result of the introduction of aversive physical sensations from sexual activity. Additionally, this reduction in engagement in sexual activity leading to painful outcomes has negatively reinforced her feelings of guilt and shame surrounding not only sexual activity, but also her relationship with Paul in general. Jane continues to experience ongoing feelings of shame and guilt after the reduction of sexual activities, which she now perceives as aversive due to unpredictable painful sensations. Despite Jane's ongoing feelings of shame, Jane, similar to many other individuals with rare diseases, experiences a hope for change, particularly after starting new orphan drug therapies (Wastfelt, Fadeel, & Henter, 2006).

### Case Scenario Goals and Treatment Planning

Jane initially presented to counseling with concerns about her relationship with her partner. These concerns continue to be evident after a more thorough exploration of the experiences and reasons behind Jane's presenting concern related to her rare disease. Notably, the direction for treatment can be driven by Jane's fears regarding adverse physical outcomes from engaging in intimate and sexual activity with Paul – and her resulting feelings of shame and guilt – while remaining consistent with a behavioral theoretical conceptualization of the client's situation. Jane's chosen long-term goal can be understood as increasing intimate behaviors with

her partner. This long-term goal may be broken down into two separate short-term goals: a) deconditioning fear related to intimate behaviors with Paul and b) increasing effective communication behaviors with Paul.

### Short-Term Goal and Treatment Planning: Deconditioning Fear of Intimate Behavior

**Systematic desensitization.** Systematic desensitization involves the notion that one cannot be tense and relaxed simultaneously (Wolpe, 1968). In using systematic desensitization, Jane can work on extinguishing the conditioning of fear with intimate behaviors and instead pair feelings of relaxation with her thoughts toward intimate behaviors with Paul. In doing so, a counselor would first have Jane identify a fear hierarchy, in which she allocates a level of fear toward different types of intimate behaviors. She may start with the thought of kissing Paul on the cheek – potentially a lower-level fear that could still lead to unpredictable swelling of her mouth's mucosal tissues – and work her way up to the thought of penetrative intercourse with Paul, which could lead to unpredictable swelling in her genital region and resulting pain. Once a fear hierarchy has been developed, the counselor would help Jane learn relaxation exercises, such as progressive muscle relaxation, deep breathing, or mindfulness. After Jane practices relaxation techniques, the counselor would then start the systematic desensitization process. In this process, the counselor would ask Jane to imagine various items on her fear hierarchy, starting from the lower-level fears and gradually working up to the higher-level fears. Jane would perform her relaxation techniques simultaneously while imaging her fearful events. As such, she would work toward classically conditioning feelings of calmness with fearful thoughts about intimate behaviors, so as to reduce the experienced fear presently paired with them. Gradually, from working through her fear hierarchy in this manner, Jane could learn to extinguish perceived feelings of fear with thoughts of engaging in intimate behaviors with Paul.

**Sensate focus.** Sensate focus can also be used as an alternative to systematic desensitization that involves moving through a hierarchy of intimate behaviors with a partner, so as to reduce fear associated with engaging in intimate and sexual behaviors (Linschoten, Weiner, & Avery-Clark, 2016; Weiner, Cannon, & Avery-Clark, 2014). Sensate focus involves five stages which focus on intimate touching for one's own understanding of how temperature, pressure, and texture affect the individual's physical sensations (Weiner et al., 2014). Clients and their partners start by taking turns exploring each other's bodies through touch, while avoiding intimate areas such as breasts and genitals. As couples continue to move through the stages of sensate focus, they gradually involve more intimate areas, mutual touching, mutual touching with genitals making external contact, and moving to

ward genitals making internal contact. Even if arousal occurs, the practicing partners are encouraged to be mindful of it, but not focus on it or demand that arousal lead to orgasmic completion. The focus is not on one's own pleasure or partner's pleasure – but rather, the focus is on understanding and building awareness of how one's body responds to intimate physical sensations.

For Jane, learning about sensate focus in individual counseling and then introducing the process to Paul at home could help her unpair her current feelings of fear with engaging in intimate behaviors by increasing her understanding of what physical sensations and intimate behaviors her body responds to safely without leading to signs of impending swelling. During the earlier stages of sensate focus in which intimate areas are avoided, she could include any areas involving mucosal tissue since those have presented risks for unpredictable swelling in the past. For more detailed information on the stages of sensate focus, refer to Weiner et al. (2014). No known research exists examining the use of sensate focus for intimacy concerns in clients with HAE; however, sensate focus may be a helpful tool for clients seeking to address their sexual wellbeing with a partner as a relevant basic physiologic need (Maslow, 1943). Before suggesting sensate focus to clients with HAE or other rare diseases, counselors would want to have cleared such behaviors with the client's healthcare team.

### **Short-Term Goal and Treatment Planning: Increasing Effective Communication Behavior with Partner**

The second short-term goal involves Jane increasing effective communication behaviors with Paul. This second short-term goal is influenced by the conceptual understanding of (a) Jane's denial of activities after experiencing significant pain during sexual activity and (b) Jane's continuation of feelings of shame and guilt after denying activities as having been operantly conditioned through positive punishment and negative reinforcement, respectively. Therapeutic approaches for increasing effective communication behaviors with Paul may involve assertiveness training or couples counseling to increase Jane's advocacy of her own needs and limits related to intimate behaviors. These strategies may also encourage Paul to express his thoughts on having his needs met, as well as provide a space for Jane to engage in conversation about her feelings of guilt and shame.

**Assertiveness training.** Wolpe (1968) identified assertiveness training as one approach to reciprocal inhibition – the process of experiencing relaxation while simultaneously imagining or experiencing an anxiety-inducing situation. Some individuals may experience anxiety related to discussing their needs and limits related to intimate behaviors with others. However, the importance of communicating intimate and sexual needs has been found to be crucial for emotional well-being, especially that of women (Ferroni & Taffe,

1997). For individuals experiencing fear of verbally asserting their needs and limits, sensate focus may provide a non-verbal way to assert one's physical preferences and improve overall communication within relationships (Linschoten et al., 2016). The use of handriding – placing one's hand over a partner's hand during sensate focus to non-verbally communicate positive or negative sensations – may positively reinforce and communicate behaviors leading to comfortable sensations while negatively punishing and communicating behaviors leading to uncomfortable sensations (Weiner et al., 2014). If Jane were to perceive initial signs of potential swelling, she could guide Paul's hand away from that area to communicate a limit against continuing to touch that part of her body at that time. If Paul were to avoid areas that had previously led to swelling, but Jane was not getting initial signs of potential swelling during a particular instance of sensate focus, she could guide Paul's hand to that part of her body to communicate approval of him touching her there at that time. In this way, sensate focus can also help alleviate anxiety for partners of individuals with medical conditions with inconsistent symptomology who may be afraid of hurting their partner during intimate activities (Linschoten et al., 2016).

**Couples counseling.** Counselors can also invite partners to participate in couples counseling to provide an open and safe space to communicate a variety of needs within the couple's relationship. D'Ardenne (2004) wrote about ways in which couples need to develop coping strategies when one partner within a relationship has been diagnosed with a long-term illness, due to having to modify activities of daily living depending on the nature of the illness. Similarly, couples experiencing medical illness within their relationship may find themselves needing to renegotiate ways of being sexually intimate and satisfying each other's sexual needs, within the confines of any physical limitations or concerns related to the illness (Gilbert, Ussher, & Perz, 2008).

In the case scenario, Paul could be encouraged in couples counseling to express his current thoughts regarding the present lack of intimate behavior and discuss potential coping strategies to allow for him to meet his needs while also respecting Jane's physical comfort level. Additionally, Jane could openly communicate about her current feelings of guilt and shame about the decrease in their intimate activities, her denial of Paul's advances, as well as her fear of Paul leaving the relationship to meet his sexual needs in other ways (Esmail, Munro, & Gibson, 2007). Due to Jane having a rare and long-term illness, her physical sensations of unpredictable and life-threatening swelling are unlikely to simply go away or have simple solutions. The couples counselor can invite Jane and Paul to openly express their feelings and their thoughts on how they can safely modify and re-evaluate intimacy for Jane's safety (Appleton, Robertson, Mitchell, & Lesley, 2018). The couples counselor could also encourage

Jane to speak with her healthcare providers about how her physical illness is affecting her psychosocial wellbeing and relationship with Paul, which are important elements of palliative medical care (Cort, Monroe, & Oliviere, 2004).

### Implications for Counseling Practice

One of the first overall implications for counseling practice involves counselors increasing their competency on issues pertaining to sexual wellness in counseling, as well as their comfort in discussing these sorts of issues in counseling. Hipp and Carlson (2019) speak to this important need in their recent article in *The Family Journal*. Without competency in discussing sexual issues with clients, counselors may lead treatment from their own potential countertransference or personal value system, instead of working collaboratively with clients toward validating their experience of sexual and intimacy difficulties while living with a serious medical illness and offering appropriate treatment approaches. Without comfort in discussing sexual issues with clients, counselors may ignore their clients' sexual concerns entirely, leaving them to continue feeling alone and their social wellbeing ignored by treatment professionals (Mercadante, Vitano, & Catania, 2010).

The recent creation of the Association of Counseling Sexology & Sexual Wellness (ACSSW) through the American Counseling Association speaks to the importance of sexuality in counseling being understood and discussed more openly as a counseling competency. The ACSSW's (2019) Research and Scholarship committee is currently working on developing a list of counselor competencies "in the area of human sexuality that professional counselors should be expected to demonstrate as part of their independent practice" (Research and scholarship section, para. 2). These upcoming professional resources aim to enhance counselors' knowledge base and skillset in working with client sexuality issues in counseling.

A second implication for counseling practice involves counselors engaging in interdisciplinary collaboration with healthcare professionals when working with clients experiencing concerns influenced by medical conditions. This becomes especially important when a client has a rare disease. Ideally, counselors would want to obtain a release from the client to speak with the client's healthcare team. If the client does not currently have a healthcare team or does not trust their healthcare team's knowledge of their illness, a medical consultation with an expert on that condition could assist the counselor in better understanding how the disease may impact the client's psychosocial wellbeing and relationships. When counselors understand the client's medical situation, they can help the client learn to modify activities of living and live life with the disease, rather than just focus solely on the disease itself (Jensen et al., 2018).

Similarly, a third implication for counseling practice in-

volves counselors advocating for clients' holistic wellbeing when clients have a medical illness or rare disease. Palliative care is a medical care model with a focus on symptom management and maximizing holistic quality of life (National Coalition for Hospice and Palliative Care, 2018). Unfortunately, due to a general lack of knowledge and confusion with hospice care, palliative care is infrequently offered to individuals with long-term rare diseases (Adams, Miller, & Grady, 2016). If counselors enhance their knowledge about palliative care and holistic wellbeing for individuals experiencing medical conditions, they could provide psychoeducation about palliative care and encourage clients to broach the topic with their healthcare providers. This may be especially crucial if clients do not perceive their healthcare provider as viewing their sexual wellness as an important medical concern, in comparison to treating the rare disease (Mercadante et al., 2010). Additionally, counselors could provide psychoeducation on the importance for clients to advocate for their emotional, social, and spiritual needs with their healthcare providers, in addition to their physical needs (National Coalition for Hospice and Palliative Care, 2018). In the case scenario above, the counselor could suggest Jane practice advocating for these various needs to her healthcare team as a part of assertiveness training. Although counselors cannot provide medical treatment and are not medical experts, they can empower clients with information so they can advocate for their own medical and palliative care needs with their healthcare providers.

### Conclusion

Among the many secondary concerns that may accompany a rare disease, concerns related to sexual wellness may be among those less frequently addressed by healthcare providers. When this is the case, counselors may find themselves seeing these clients, even though clients may not present with an initial concern clearly relating to their sexual wellness. This article discussed a case scenario involving a client living with a rare disease called HAE, the symptoms of which present challenges to her intimate and sexual relationship with her partner due to unpredictable and painful swelling. By viewing the case scenario through a behavioral theoretical lens, and allowing that theoretical lens to inform treatment, a counselor could work with this hypothetical client to address her feelings of fear of engaging in physical intimacy with her partner, as well as her feelings of shame and guilt related to denying sexual advances from her partner. When counselors can become competent in working with sexual wellness issues and comfortable exploring these concerns with clients, clients may perceive their concerns being heard and addressed by a professional for the first time since receiving their medical diagnosis. By counselors approaching client sexuality concerns with competency and willingness to discuss them, counselors may be able to empower

clients to bring up these valid concerns with their healthcare providers in order to explore their treatment options. In doing so, counselors may help enhance an element of quality of life for individuals with rare diseases and serious medical conditions.

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# Using Surrogate Partner Therapy in Counseling: Treatment Considerations

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When working with clients on issues of sexuality, clinicians often avoid the treatment approach of surrogate partner therapy due to lack of information and understanding. Surrogate partner therapy is a grey area within legal and ethical boundaries of various mental health professional associations. This article offers an intensive exploration of surrogate partner therapy, including its history, ethical considerations, benefits, and challenges. Best practices and treatment considerations when working with a surrogate partner therapist are discussed. Although there is a lack of research and evidence-based practice information, the available literature demonstrates that surrogate partner therapy is an effective intervention that can enhance treatment for clients struggling with sexuality and intimacy issues.

*Keywords:* sexual surrogate, counseling ethics, surrogate partner, sex therapy

## Introduction

Sexualized messaging is pervasive in the United States, with eroticized images saturating movies, news, music, television, and social media; however, despite its ubiquitousness, sex remains a highly stigmatized and taboo topic (Jacobs, 2010). Research indicates that an affirming and inclusive relationship to sexual health, sexuality, and sex-positivity is critical for mental health wellbeing (Laumann, Paik, & Rosen, 1999; Wincze & Weisberg, 2015), yet meaningful discussion of these body-positive ideas is discouraged. Furthermore, studies show that clients are hesitant to start conversations about sexual functioning as they believe it is the counselor's prerogative to broach topics and provide resources; meanwhile, counselors are waiting for their clients to initiate these discussions (Abramsohn et al., 2013; Althof, Rosen, Perelman, & Rubio-Aurioles, 2013; Kingsberg, 2004; Lindau et al., 2007; Wimberly, Hogben, Moore-Ruffi, Moore, & Fry-Johnson, 2006). With clinicians and clients struggling to engage in conversations about sexuality issues and sexual concerns, many issues may go unresolved, or worse, unreported.

Even if a clinician and client are open and honest in their discussion of sexuality issues, limitations remain regarding which tasks can be ethically accomplished inside and outside of session, especially if a client lacks a supportive relationship partner. In these cases, surrogate partner therapy (SPT), formerly known as "sexual surrogacy or sexual surrogate therapy," is proposed as a beneficial tool and resource to aid in therapy. Surrogate partners (SP) allow clinicians to work with clients in a way that traditional therapists cannot due to legal and ethical limitations that bind counselors. An SP is a highly trained individual who acts as a "stand-in" or

"surrogate" when a client is in an ongoing struggle with a sexual or intimacy issue in therapy and is unable to resolve it on their own without a partner. Crucially, SPT allows a client to practice techniques taught in session and engage in exposure therapy. To illustrate, while a counselor can work with a client who has an extreme phobia of heights and explore the etiology, cognitive distortions, and techniques for resolving the problem, eventually, the client will have to engage in exposure therapy (to face that fear) and report back to the clinician. Similarly, SPT provides the client with access to a safe partner for practicing de-sensitization techniques among other skills.

Although SPT is designed to help clients achieve their goals of sexual health and wellness, it remains an underutilized, unacknowledged, and unsupported modality in sex therapy. Highly stigmatized, SPT has been viewed as a controversial approach to client care since it was first established by Masters and Johnson in 1970 to treat sexual dysfunction (Masters & Johnson, 1970). This is partially due to the misconceptualizations that surround the practice, its efficacy and

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the ambiguity regarding legality in the field of counseling and psychotherapy. Apfelbaum (1977) suggests if SP's were called "therapeutic partner," much of the stigma surrounding the therapy might have been avoided, though this term could be misleading to clients since a SP is not a trained therapist. However, despite this distinction, SPT is a regulated profession with a rigorous selection and certification process which requires SPs to receive specialized training in areas of intimacy and human sexuality, clinical sexology, SPT therapy, and professional issues.

### **Surrogate Partner Therapy**

Surrogate partner therapy is a treatment modality used in sex therapy to assist clients with a host of issues that relate to sexual wellness and intimacy. Surrogate partners provide intimate services to a client under the consultation of the client's licensed mental health clinician ([International Professional Surrogacy Association, 2019](#)). For successful therapy to occur, there must be a triadic relationship that forms between a licensed clinician, the client, and a certified SP. Constant communication between the client, SP, and clinician helps to ensure the most therapeutic benefit to the client. The clinician engages in treatment through talk therapy with the client, and if the clinician and client cannot tackle the presenting concern independently, consultation with the SP is an option. Following this conference, the SP and client meet in their own private session, develop a treatment plan on their own (while keeping the clinician in the loop) and may utilize techniques such as psychoeducation, touch, intimacy, or sexual activities to help the client reach their goals. After every meeting between a surrogate and a client, both individuals talk with the clinician to decide the next phase of treatment. This also opens the lines of communication between a clinician and a client who may struggle with sharing the necessary details of their sexual concerns. By encouraging this triadic relationship and cyclical process, surrogate partners can assist clinicians with gaining a more complete picture of the issue and help determine the most appropriate goals for treatment.

According to the International Professional Surrogates Association (IPSA), clients seek SPT for a host of issues, which can include: medical conditions, which affect sexuality or sexual functioning; abuse that can cause discomfort in intimacy or sexuality; lack of self-confidence; sexual orientation concerns; dissatisfaction in sexual performance or orgasms; fear of intimacy; lack of arousal; shame and anxiety; lack of the ability to form relationships; or even self-esteem concerns. Any concern that a client presents with must be addressed in ongoing therapy prior to pursuing this modality safely. An IPSA certified SP will not accept clients who have not been in therapy for the concern. IPSA (2019) further asserts that the use of a surrogate becomes helpful when problems persist, and a client cannot achieve the de-

sired outcome on their own as SPT can address the areas that a clinician cannot breach. In certain contexts, therapy has specific limitations; for example, a clinician can send a client home with assignments to complete on their own, but if a client does not have a supportive partner to perform some of the assignments, treatment and progress can become difficult. For instance, a client suffering from trauma or abuse might be helped by working through negative or triggering cognitions in therapy, but helping desensitize a client to touch can be an ethical violation for therapists. Utilizing an SP enables the client to be desensitized systematically to touch and to create positive associations with this action, which further enables a healthy social and sexual life.

SPT is a form of sexual rehabilitation for the client. When therapeutically necessary, sexual intercourse, oral-genital stimulation, and other sexual activities can occur between the SP and the client as they work their way through a series of clinically indicated therapeutic exercises to assist the client in their sexual wellness. Each step that a SP takes is included in the treatment plan and discussed within the triadic relationship with the client's therapist, so the activities can be processed in the session with the clinician, much like any other therapeutic homework assignment. However, sexual contact of any kind is never assumed or promised at the start of therapy. The course of therapy with a SP is determined by the therapist, SP, and client in a stepwise progression that makes sense to the treatment goals. Surrogate partner therapy is described to have four phases: (a) emotional connection and bonding through verbal communication; (b) bodywork and becoming comfortable with touch and sensual touch; (c) sexual intimacy as deemed appropriate by the client's comfort level and treatment plan with the clinician; and (d) closure and termination. Therapy is terminated with a SP when the therapist, client, and SP agree that the therapeutic goals have been met. Afterward, the client remains in therapy with the clinician, while the SP and client terminate their relationship permanently. The therapist can then assist the client in any remaining goals and integrating what the client learned with the SP into life situations.

SPs can engage in a sexual relationship with the client, but their role is often not purely sexual. In fact, Rosenbaum, De Paauw, Aloni, and Heruti (2013) noted that non-erotic activities and exercises, sexual education, and social skill development make up the predominant amount of time that is spent with clients. SPs can teach clients how to develop healthy relationships, make connections, understand social and intimacy cues, receive and give touch, and accept one's body. Additionally, SPs provide education and information through experiential exercises designed to teach skills such as interpersonal communication, eye contact, and using appropriate manners on a date. These are skills that someone may not be able to gain without a partner in practice. Thus, the surrogate serves as a model for the client to learn and grow personally,

emotionally, and sexually.

### **Surrogate Partner Therapy vs. Sexological Bodyworkers**

Bodyworkers are individuals whose job it is to focus on the body in such tasks as “assessing, diagnosing, handling, treating, manipulating, and monitoring bodies” (Twigg, Wolkowitz, Cohen, & Nettleton, 2011). The term “bodyworker” encompasses jobs such as hairdressers, massage therapists, and tattoo artists, as well as extending to sex workers and undertakers. Surrogate partners and sexological bodyworkers (SB) are also considered forms of bodywork. Although these two professions sound the same, their implementation is very different. Whereas SP training is based in interpersonal skills and relationships, SB training is based in massage techniques to help clients overcome their sexual difficulties. SPT is often viewed as more controversial than sexological bodywork because it is a two-way relationship with the client. SPs not only train their clients on how to receive touch, but also on how to provide healthy and mutually satisfying touch. In contrast, although SBs are trained professionals under the Association of Certified Sexological Bodyworkers (ACSB) and certified following a code of ethics, touch experienced in sexological bodywork is unidirectional and the SB does not receive touch or any sort of sexual satisfaction from the client (ACSB, 2019). As such, SBs encourage their clients to find a practicing partner; thus, if a client does not have a partner, they are put into another difficult situation. For example, if you have a client who is struggling with premature ejaculation and they have anxiety when in sexual situations with a partner, eventually with a SB, they will have to find a partner to practice with. This creates a new set of challenges for the client with anxiety. They may be worried about their own performance, but also their partner’s satisfaction. With a SP, they would be able to practice with the SP and face this anxiety head on in a safe environment where challenges could be discussed. The two way touch allows the SP to give and receive touch. SB’s are not able to do so because they cannot be touched in return. SB’s also do not have to be in current therapy with a clinician, nor do they have to maintain a triadic relationship with the client and the therapist. Ultimately, if the client experiences a mental health situation or concern, there is no therapist present to help the client process the issue (ACSB, 2019).

### **Surrogate Partners vs. Sex Workers**

Surrogate partner therapy has been highly criticized because SPT is viewed by some as a form of sex work. Furthermore, many also consider SPs as no different than sex workers (also referred to by the stigmatized term, “prostitutes”). However, this view is often values-based and holds no merit. According to Rosenbaum et al. (2013), the crucial difference between a sex worker and a SP is that the sex worker is there

to gratify specific sexual desires, whereas the surrogate is a trained part of a therapy team. Only 13% of a surrogate’s job is devoted to sexual activities. The majority of a surrogate’s time is focused on non-erotic activities and exercises, sexual education, and social skill development (Rosenbaum et al., 2013). When analyzing the amount of time spent with clients across various categories, Freckelton (2013) found the surrogates reported the following percentages: 32.10% touch related activities (such as body awareness and positive touch); 17.69% reassurance, support, and validation through talking; 16.41 % information providing; 16.39% non-sexual experiential activities; 12.69% sexual activities; 4.39% social outings or activities to teach skills; and 1.31% observation in social situations. Overall, these findings demonstrate that clients spend the vast majority of time engaged with SPs in non-sexual activities. If a client were strictly seeking sexual intercourse or gratification rather than a therapeutic intervention to help explore sexuality concerns, an IPSA-certified SP would not be a good fit. SPs screen all clients and do not take clients if they are not eligible for services and if they are not in current and ongoing therapy with a clinician. In sum, SPT is viewed as an additional therapeutic resource when a clinician has exhausted other traditional options and cannot assist a client on their own.

### **Challenges**

In the 1977 article “The Myth of the Surrogate,” Bernard Apfelbaum (1977), perhaps one of the most notable critics of the SPT movement, identified many of the pitfalls of Masters and Johnson’s (1970) initial treatment protocol, such as the name and role of a SP. Although many of the initial issues have since been resolved, it is important to understand the theoretical underpinnings of the early movement. One primary criticism is that when the concept was originally developed in the ’70s, the SP was conceptualized as a “fantasy wife.” Masters and Johnson (1970) stated that the function of surrogate was to act in a role that was a “supportive, interested, and cooperative wife” (p. 150). The initial model severely restricted and minimized the therapeutic aspect of SPT, as it forbade asking the SP personal questions and even went so far as to ban asking how the SP was feeling. This restricted treatment and educational components that are vital to the modality. The surrogate was to be considered a blank slate, not a member of the therapeutic team, but instead a means to fulfill what was lacking in the (at that time) male client’s needs. Thankfully, this is one of the many changes made to the program since the initial trials in the ’70s. Today, the SP and the client talk about how they are feeling and what they like in tandem; dialogue is integrated into the SPT model (IPSA, 2019). This addition allows for more accurate modeling of a relationship and for the client to know if actions are positive as well as how to take cues for mutual respect and pleasure. Open communication is especially

important when it comes to social skill development and relationship building. Today, SPs are male, female, and gender fluid, and they come from many different sexual orientations, which further resolves the issue of SPs being intended for one gender.

Even though the role of a SP has changed over the years and some of the stigma has been alleviated, there is still a long way to go for the profession and those seeking services. According to Masters, Joshnson, and Kolodny (1977), sex therapy, by definition, is couple's therapy. The practice of sex therapy cannot happen without practical application and experience with a partner (Masters et al., 1977). This leaves those unpartnered males, females, and non-binary people with an even greater stigma when entering into sex therapy. This stigma is coupled with stereotypes of what it means to be male or female and a lack of sex-positivity and sexual wellness promotion across genders.

### **Professional Associations**

Many therapy and counseling professionals (such as marriage and family therapists, psychologists, social workers, and counselors) have codes of ethics that detail the importance of referring clients for additional services that would benefit or be in the best interest of the client. These referrals include services that are outside of the scope of practice or competence for the clinician. In the field of mental health, one might assume that professional associations would support the referral of a client to a SP for additional support in resolving an issue that has not been successfully resolved through talk therapy alone. However, due to the stigma that still surrounds sex and sexuality, this should not be assumed. Binik and Meana (2009, p. 1021) state that the use of surrogates is "no longer sanctioned" by many professional therapy groups. There has been no official support, sanction, or position on the use of SPT by the following major professional organizations: American Counseling Association (ACA), American Association of Marriage and Family Therapy (AAMFT), and National Association of Social Workers (NASW). In 2013, the American Association of Sexuality Educators, Counselors, and Therapists (AASECT; 2013) published the article "Sexual Surrogacy Revisited," which addressed the controversy and stigma surrounding the topic of SPT. AASECT noted that the stigma surrounding SPT is largely exacerbated by counseling professionals' reluctance to discuss its use, as well as the lack of professional organizations that support the practice; however, AASECT described their own position on the practice of SPT therapy as "nebulous" (AASECT, 2013, p. 5). Aside from this article, no other statement or official stance on the practice of SPT could be identified on AASECT's website or through available publications. Due to the dearth of readily accessible information on SPT from professional associations, both professionals and clients find it challenging to have their ques-

tions answered and to feel supported and confident in their decision to use this approach (Zur Institute, 2019). All of these organizations promote sex-positive and affirming approaches to sex and sexuality, yet the lack of willingness to support and thoroughly discuss SPT, its use and effectiveness in clinical practice, leaves clinicians in a double-bind.

### **Legal Concerns**

Many legal concerns surround the use of SPT. Surrogate partner therapy is not formally recognized as a legitimate form of therapy, nor is it regulated by government licensing boards. As SPT remains undefined in most of the United States and worldwide, IPSA has taken on the responsibility and standards of guiding the profession (IPSA, 2019). This includes standards of care, competence, and training of SPT. However, among mental health professionals, there is still a pervasive fear regarding potential legal consequences resulting from the recommendation or use of a surrogate with a client. This concern stems from more personal techniques of SPT, including intimate touch and forms of genital stimulation. Even though SPT is therapeutic, the SP is trained, and the relationship is noncoercive, intimate techniques are viewed by some critics as sex work or even as a form of sex trafficking because the SP is paid for services rather than engaging completely altruistically (Zur Institute, 2019). The World Health Organization (2002) defines sex work as any non-coerced or forced commercial exchanges of sexual services by people of all genders and sexual orientations for remuneration or money. Although the Kinsey Institute (2019) identifies the practice of SPT as controversial, it is noted that as long as the SP works under the supervision of a licensed therapist, there should be no legal concerns.

Due to concerns about the societal perceptions of their profession as a form of sexwork, many SPs avoid advocating for and advertising on behalf of their profession in public forums. However, the chief point remains that SPT is not about sexual gratification. It is a therapeutic tool to teach people skills, to build social and physical confidence, and to create self-awareness to help people overcome sexual challenges that may be blocking them from healthy intimacy and achieving optimal sexual wellness and functioning (IPSA, 2019). Sexual contact and gratification are never required nor dictated as part of any treatment plan. They are only used as part of a treatment plan if deemed ultimately necessary for the client to reach their goals. If the client can attain their goals without achieving intercourse, then intercourse is not introduced into the treatment plan (IPSA, 2019). Whether or not to engage in a relationship with a SP is a mutual choice on behalf of both parties, which requires contractual informed consent, just as there would be in a traditional therapeutic relationship between a client and therapist. The client and SP can terminate the relationship at any point or change the treatment plan to address the comfort level of the client.

Recently, the Fight Online Sex Trafficking Act and Stop Enabling Sex Trafficking Act (FOSTA-SESTA) were signed into law on April 11, 2018. These two acts are intended to prevent sex trafficking but were so broadly defined that they have the profound ability to limit and punish consensual sex workers, such as body workers, SPs, and even the adult film industry (in states where adult film is not distinctly defined from sex work). FOSTA-SESTA makes it increasingly difficult for SPs to advertise and screen clients safely and effectively; additionally, it also criminalizes the work of legitimate public health messaging and sex education efforts, and further silences the actual victims of sex trafficking. AASECT considers FOSTA-SESTA to be a critical threat to membership and fundamental human rights to sexual knowledge and education. AASECT (2019) notes they support “the rights of sex workers to choose this work and to have access to resources that make sex work safer, including online advertising platforms” (para. 7). The organization also distinguishes between consensual sex work and sex trafficking and coercion. Furthermore, AASECT goes on to recognize that “sex workers, including sexological bodyworkers, surrogate partners, professional dominants, and lifestyle educators sometimes facilitate the work of sex educators, counselors, and therapists by providing hands-on adjunctive treatment services” (para. 9).

There is currently no official law in any state that speaks directly to SPT as a legal practice, but in over 40 years of its use, there has never been a successful legal challenge to IPSA-certified surrogates or clinicians who work with SPs (IPSA, 2019). In an examination of state laws, there is little available information or mention of the use of SPT. Most states do not ban or condone it. In an article titled “Sex surrogate says her mission is to help the dysfunctional” in the San Jose Mercury News (1977) in California, Kamala Harris (current US senator and formerly of the Alameda County District Attorney’s office) states, “If it’s between consensual adults and referred by a licensed therapist and doesn’t involve minors, then it’s not illegal.” An Arizona defense attorney, Scott Maasen, has noted that SPT falls into a gray area and should be considered a therapeutic method and a form of coaching. SPT also invites questions about privacy as law enforcement has a difficult time enforcing the vagueness of privacy law (Hessedal, 2013). Gaining knowledge and understanding about the practice of SPT, referral process, IPSA-certified therapists, and the way a triadic relationship works is integral to preventing legal pitfalls. If properly practiced, legal concerns are largely avoidable, and no case has been prosecuted against a therapist or SPT (Hessedal, 2013).

### **Ethical Concerns**

The goal of IPSA is to provide consistent standards and ethical guidelines for the professional practices of SPT therapy. Ethically, a client who is in distress and turning to a SP

for assistance could be placing themselves in an emotionally vulnerable situation. This could pose unique challenges for the clinician as the client could become attached to the SP, experience transference with future partners, and/or develop an unrealistic expectation for a future partner who may not be as supportive and understanding as a surrogate (Appleyard, 2011). This is why it is critical for the referring mental health professional to know their client and understand the practice of SPT well enough to make appropriate referrals and recommendations.

While SPs must adhere to training protocols and standards required for certification, if a client becomes emotionally unstable due to interpersonal challenges or trauma while in a SPT session, the SP may not have enough training to recognize the client is in crisis. Surrogate partners are not trained as mental health clinicians; they do not have psychological training and are not authorized to recognize crisis or to give professional and ethical guidance as such behavior could lead to potential danger for the client. This is why the triadic relationship in SPT therapy is critical, and it is necessary for the mental health clinician to check in with the SP after each session.

Furthermore, chiefly due to legal and ethical concerns, SPT therapy currently lacks a strong and concrete evidence-base, and there is little collective and vetted data that support its use and long-term effectiveness as an intervention (Freckelton, 2013). Research being done on SPT is predominantly from Israel, where SPT is legal. All other information focuses on the ethical concerns and challenges, not the efficacy of the practice. This said, there is currently no data that shows SPT has ever harmed a client or SP. The limited research that is available and presented below supports the assertion that SPT helps clients.

Last, SPT therapy can be costly for clients. Surrogate partner therapy is not recognized by most professional organizations, let alone by most insurance panels. This means that this beneficial service is not available for all clients of various socioeconomic brackets. SPT services can only be referred to those clients who can afford it. Thus, like many other forms of therapeutic services, this treatment modality is not one that promotes the ethical responsibility of justice and fairness, as global barriers remain for many people who seek health services that may be deemed as “unnecessary” by insurance panels.

### **Benefits**

Surrogate partner therapy is for just about any client who is having trouble overcoming a sexual or intimacy-related issue that has not been resolved through therapy alone. SPT works for clients of all sexual orientations and genders; those who are able-bodied or with physical impairments; and those with autism, anxiety, trauma, recurring relationship issues, lack of confidence, and sexual difficulties. There are many

documented cases where SPT therapy has helped clients living with disabilities and sexual functioning concerns to overcome obstacles. Clients who have sustained a brain injury or other recent physical challenges still have sexual desires and needs that may be unexplored and unmet. Having someone who can teach ways to have a satisfying sexual life in spite of these challenges is critical for someone's overall well-being. To this end, Aloni, Keren, and Katz (2007) discuss the benefits of SPT for "individuals with very limited functional ability following traumatic brain injury" by presenting a case study of a client suffering from a traumatic brain injury after a major car accident that greatly hindered the client's physical and intellectual abilities. Prior to the accident, the client was in a long-term relationship and showed no lack of social skills or sexual concerns. After the accident, the client was inappropriately touching both his sister and her friends. The client underwent 16 weeks of SPT and showed vast improvements in his behaviors. The client was taught how to self-stimulate and was able to satisfy most of his sexual needs on his own, as he learned through therapy about SPT boundaries and appropriateness (Aloni et al., 2007).

One of the greatest misconceptions about SPT is that it is a modality reserved for people with physical limitations, which is the biggest hurdle that exists for researchers searching for general information in the available literature. Relating SPT to those who are physically suffering seems to make SPT more acceptable and "condoned" by the public, yet this conception reduces perceptions about the use and capacity for SPT to help those who suffer from debilitating anxiety, incapacitating self-doubt, body image concerns, and self-consciousness concerns. Recently, literature has been published to acknowledge the impact a SP can make in sexual identity concerns. Poelzl (2011) demonstrates how she was able to guide a woman through her successful journey of finding her bisexual orientation through support and acceptance with help from SPT. Dauw (1988) examined the success rate of SPT in cases of sexual dysfunction. The study consisted of 489 heterosexual males suffering from a form of sexual dysfunction. Ninety-seven percent (97%) of the participants sought SPT on their own after they had exhausted the traditional routes of therapy to no avail. The study had a 6% attrition rate, reportedly due to financial concerns. After a three-month follow-up survey, the results showed an 89.78% success rate. The clients reported positive results that were not achieved in traditional therapy alone without utilizing a SP. Likewise, Ben-Zion, Rothschild, Chudakov, and Aloni (2007) conducted a similar study to evaluate women suffering from vaginismus and concluded that women lacking a cooperative partner would be unable to participate in the conventional treatments for vaginismus. Surrogate partner therapy was found as an effective option that would benefit clients the most. The results of the study showed that all 16 participants with vaginismus had a 100%

success rate in treating vaginismus with SPT as opposed to traditional couples therapy.

Most recently, SPT therapy was introduced in season four of the documentary series "This is Life with Lisa Ling" (Dennett, Shastry, Buxton, Panagopoulos, & Ling, 2017). An episode called "Sexual Healing" (season four, episode one) documents two men's stories of sexual healing through surrogacy. In both instances, the client's journey is not focused on sex and sexual gratification. Instead, the two men were looking to heal in various ways that could not be achieved through traditional talk therapy alone. In conjunction with SPT, these men were able to start their healing processes and learn more about themselves, their sexual health, and needs for intimacy.

### Considerations

Before incorporating an SP into one's practice, a mental health clinician should sort through their own personal beliefs and biases about the profession and sex work in general. If a clinician is not knowledgeable and aware of how the practice works, then research needs to be completed before ever recommending the service. Additionally, if the clinician holds their own values-based biases, SPT should not be adopted because a strong therapeutic triad is required for therapy to be effective. The clinician and SP need to foster open and consistent communication, and to trust each other's work. Clinicians must do their due diligence to assist the SPs in working with clients. It is fully recommended for clinicians to do their own research on SPT before collaborating with one in their practice. As the governing body for the profession, IPSA would be the organization to reach out to in order to find out more information about connecting with a SP.

The goal for SPT is to help SPs to fully establish themselves as serious, responsible, and professional sexual health workers who are fully a part of the therapeutic spectrum (Freckelton, 2013). According to Freckelton (2013), there are some key issues that require careful consideration before a clinician should recommend or support the use of SPT. When establishing the parameters of the therapy, a clinician needs to evaluate if the client is capable or emotionally stable enough for each stage of SPT. The clinician should also research state laws and the possible outcomes of SPT. While there have been no recorded legal proceedings against a therapist for being involved in SPT, a clinician needs to become knowledgeable in this area. Freckelton (2013) points out that IPSA's code of ethics does not bar the surrogates from developing a personal relationship with the client. The client's readiness for such an approach needs consideration, along with the ways this could change the course of therapy for the client and the relationship with the therapist. Freckelton (2013) notes several questions to review: (a) what is the extent of the role that the therapist should play in the initiation

of this type of service; (b) who should set up the meetings or even the initial call; (c) what type of impact would this triadic relationship have on therapy; (d) should the referring therapist be the one to select the surrogate; (e) can these therapeutic goals be achieved in another manner; and (f) would adding this type of service place the client with additional burden.

When considering whether it is appropriate to use an SP, it is essential for the clinician to be aware of the limited availability of practitioners. The IPSA website has only 21 SPs listed in the United States, 15 of which are in California. There are only six states that are occupied by IPSA SPs. The lack of SPs in a client's local area could make SPT a financial burden and potentially limits many clients to intensive therapy as opposed to weekly 60-90 minute sessions. Intensive therapy typically lasts two weeks, during which time the client meets with the SP for two hours a day and a therapist for one hour a day. Treatment is typically conducted near the SP's local area, and if the client is not in the area, room and board must be covered for the SP in addition to the services provided. From a clinical standpoint, a clinician should ask if through their referred services, they are providing the most benefit to the clients while inflicting the least harm possible. Ultimately, a clinician must be comfortable with all of these areas before referring out for SPT. It is not up to a clinician to make financial choices for a client as one has to consider the client's current situation and feel confident that the referral will not do more harm than good.

### Recommendations for Best Practices

When considering using SPT, it is best to evaluate the client and their emotional state, cultural background, and openness to the idea of an SP. Engaging the client in an honest conversation is critical to the success of the technique. A client's cultural and religious beliefs might factor into the therapy portion of SPT. As such, it is crucial to reassure the client that SPT does not have to impinge on religious or cultural beliefs that may exist. SPT can work within the confines of a person's comfort level. Another important aspect is to make sure that the client is aware of the role of the SP, as well as educated about the benefits and limitations of the modality. Clients should be fully informed and aware of the implications for using SPT. The referring clinician should always contact their malpractice insurance to make sure the referral and triadic work with the SP will be covered under the clinician's policy (Zur Institute, 2019). If ethical issues should arise at any time during the SPT, the therapist should consult the ethical code of their professional association for guidance.

When making a referral, a therapist should ensure they are referring to an IPSA-certified SP, who strictly adheres to the standards and guidelines of IPSA's code of ethics. IPSA is currently the only professional organization that offers train-

ing and regulates the profession. The organization can connect clinicians and clients to IPSA-certified SPs within network. If a client chooses an SP who is not IPSA-certified, it is not recommended to refer or work with that client. Furthermore, the Zur Institute (2019) recommends that clinicians reduce liability by not being directly involved in the hiring of the SP. Although a clinician should recommend and refer a client to IPSA providers, the client should ultimately decide if they want to go forward with services. As there are not many SPs available throughout the United States, it is important to keep in mind that limited availability may make engaging in this form of therapy costly for the client. Ultimately, it should be the client's decision of which certified SP is selected and whether to go forward with services. It is also recommended that the SPT does not occur in the clinician's office (Zur Institute, 2019). The clinician can meet triadically to have any talk therapy sessions necessary with the client and SP, but SPT should take place outside of the clinician's office. The therapist should also have the client fill out a separate consent form detailing the risks and liabilities involved in SPT, as well as the need for ongoing therapy sessions during SPT. The intimate nature of the triadic relationship and termination process require a full explanation. Each SP/client meeting should be reported to the therapist, and the SP and therapist should routinely schedule a time to discuss what happened during the SPT session. Separately, the therapist should also talk with the client. If needed, there can be sessions set for the SP, therapist, and client to all meet together to discuss progress and concerns. It is essential to document each session with the client, the risk/benefit analysis, and any consulting with the SP or colleagues (Zur Institute, 2019).

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